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Office of Administrative Law Judges
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Issue Date: 08 April 2005

CASE NO.: 2004-LHC-1815

OWCP NO.: 08-117442

IN THE MATTER OF:

RAYMOND VELES

Claimant

v.

COOPER T. SMITH

Employer

and

AMERICAN LONGSHORE MUTUAL ASSOCIATION, LIMITED

Carrier

APPEARANCES:

DENNIS BROWN, ESQ.

For The Claimant

MAURICE BOSTICK, ESQ.

For The Employer/Carrier

Before: LEE J. ROMERO, JR.
Administrative Law Judge

DECISION AND ORDER

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Raymond Veles (Claimant) against

Cooper T. Smith (Employer) and American Longshore Mutual Association, Limited (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on October 12, 2004, in Houston, Texas. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Both Claimant and Employer/Carrier proffered 11 exhibits, which were admitted into evidence, without objection, along with one Joint Exhibit. This decision is based upon a full consideration of the entire record.[1]

Post-hearing briefs were received from Claimant on January 5, 2005, and from Employer/Carrier on January 10, 2005. Based upon the stipulations of Counsel, the evidence introduced, my observations of the demeanor of the witnesses, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find:

1. Claimant was injured on November 26, 1999.

2. Claimant's injury occurred during the course and scope of his employment with Employer.

3. There existed an employee-employer relationship at the time of the accident/injury.

4. Employer/Carrier were advised of the accident/injury on November 26, 1999.

5. Employer/Carrier filed Notices of Controversion on December 27, 1999, March 3, 2000, and October 17, 2000.

6. An informal conference before the District Director was held on April 26, 2004.

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[1] References to the transcript and exhibits are as follows: Transcript: Tr._____ ; Claimant's Exhibits: CX-_____; Employer/Carrier Exhibits: EX-___; and Joint Exhibit: JX-___.

7. Claimant has received permanent total disability benefits since November 12, 2001, and received temporary partial disability benefits from November 26, 1999 until November 11, 2001. As of the formal hearing, Claimant received disability benefits amounting to $87,677.40.

8. Claimant's average weekly wage at the time of injury was $507.78.

9. Medical benefits for Claimant have been paid in the amount of $64,093.22 pursuant to Section 7 of the Act.

10. Claimant suffers from a work-related psychiatric condition requiring medical intervention which is reasonable and necessary (Tr. 10-12).

11. Claimant needs pain management treatment, to his back and left knee, as a result of his work-related injury. (Tr. 11-12).

II. ISSUES

The unresolved issues presented by the parties are:

1. Section 22 modification based on a change in physical/medical condition.

2. Maximum Medical Improvement as to left knee, right knee and back.

3. Availability of suitable alternative employment regarding Claimant's left knee.

4. Whether Claimant's right knee condition is related to his work accident.

5. Whether surgery on Claimant's right knee was reasonable and necessary.

6. Reasonable and necessary medical care to include the placement of a spinal cord stimulator and health club membership.

7. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Claimant

Claimant underwent back surgery since his formal hearing on September 24, 2001[2]. He started physical therapy, but could not tolerate the therapy because it was hurting his back. Dr. Gertzbein suspended therapy and referred him to Dr. Sickler for pain management. (Tr. 29-30).

Claimant received "needles in [his] back . . ." for four of twelve prescribed treatments before Carrier suspended any further treatment. (Tr. 30).

After treatment was suspended, Claimant's back developed more problems. He had pains, could not sleep at night, and started getting panic attacks. He would get anxious because of his limitations and panic attacks would start and he could not breathe. He testified he has panic attacks three times a day. His panic attacks would begin when he thinks about things he cannot do and things he wants to do with his son. (Tr. 31-32).

Claimant informed Dr. Gertzbein about the panic attacks and Claimant was referred to a psychiatrist, Dr. Hauser. Claimant's wife made his appointment to see Dr. Hauser, but Carrier would not pay for the treatment, his private health insurance carrier did. Dr. Hauser gave him medication for the panic attacks. Claimant denied having panic attacks before the onset of his recent attacks. He paid insurance co-payments to treat with Dr. Hauser. Workers' compensation paid for his psychiatric medication, but would not approve the treatment. The medication helped lessen the frequency of the panic attacks, but did not eliminate them completely. He has side effects from the medication, such as, headaches, drowsiness and stomach-aches. (Tr. 32-34).

His treatment with Dr. Hauser was also suspended because his personal health insurance carrier only pays for a "certain amount of visits." Claimant could not recall exactly when he stopped treating with Dr. Hauser. Once he stopped taking the medication for his panic attacks, the attacks returned

[2] A formal hearing was conducted before the undersigned on September 24, 2001. Claimant was found to have a compensable work-related left knee injury and his back injury was the result of his compensable knee injury, surgery and subsequent limp. (EX-3). The decision was affirmed by the Benefits Review Board and the United States Fifth Circuit Court of Appeals. (EX-4).

"heavier." The panic attacks last 15 to 20 minutes and have caused him to go to the emergency room. (Tr. 34-35).

Claimant recently resumed treatment with Dr. Hauser and was placed on a different type of panic attack medication, which causes the same types of side effects, including, headaches, dizziness, and blurriness. He does not drive while taking this medication because of blurred vision. Claimant does not receive individual sessions with Dr. Hauser, but Dr. Hauser indicated he would like to counsel Claimant in the future. (Tr. 35-36).

Claimant's panic attacks are also triggered by his inability to return to his longshore work. He related his panic attacks to his left knee problems as well. Claimant testified "his left knee problem alone still prevent[s] [him] from returning to longshoring work." (Tr. 36-38).

After Claimant's back surgery, he continued having problems with his left knee. To relieve the pain in his left knee, he would walk on his "right foot." His right knee started getting swollen, causing "real bad pains." Trying to bend or climb stairs would make his pain worse. (Tr. 38-39).

Dr. Bryan examined both knees and determined Claimant needed surgery. Claimant's understanding of his knee problems is the doctor "needed to go back in and clean it up again because it was bothering . . . [his] knee." As to his right knee, he understood that the problem occurred because he used his right knee too much. The purpose of the knee surgery was to clean up and relieve some pain. (Tr. 39-40).

After his back surgery, Dr. Gertzbein advised Claimant he should walk, but after he started walking, his right knee problems began. In Claimant's opinion his right knee problems are related to his limping off of his left leg. Claimant used a cane to try to relieve the pain. Dr. Bryan performed surgery on both knees on June 7, 2004. To Claimant's knowledge Carrier paid the medical bills for his left knee surgery, but not for his right knee surgery. Dr. Bryan advised Claimant that his right knee problems were caused by "doing all that limping." Since the surgery, Dr. Bryan has only given Claimant physical therapy on his left knee. He has not received physical therapy to his right knee because "nobody will pay for it." (Tr. 40-42).

Claimant testified his left knee pain worsened despite his subsequent back surgery. He cannot climb stairs or kneel down.

When he lies down he cannot put pressure on his legs because it hurts him too much. He has to put a pillow between his legs to relieve some of the pressure. He also has problems getting in and out of a car because it is hard for him to pick up his knees. In addition, he has problems driving a car because the pedals are too close and it bothers him. (Tr. 42-43).

Claimant has the same problems with both knees. He can stand for "maybe 20 minutes" then has to move and walk around. He testified he can only stand and walk for a total of one hour at a time before he needs to get off his left knee completely. After the hour, he must lie down and usually falls asleep for about one hour. (Tr. 43-45).

His pain also affects his sleep. At most, he sleeps three hours at night then wakes up from pain. He also awakens from panic attacks. Claimant tries to rest during the day to catch up on his sleep. He lies down "at least twice" a day. He can sleep during the day for about one hour, but usually wakes up because his back hurts. (Tr. 45-46).

Claimant still receives bills from Texas Orthopedic Hospital from his original left knee surgery and subsequent care. These bills were turned over to collection agencies. His wife deals with the medical bills. To his knowledge, these bills have affected his family's credit rating. (Tr. 46-47).

Claimant has problems with both knees every day. They hurt all the time, but "sometimes worse than others." Prior to his knee surgeries Claimant had sharp pains. The surgery did not eliminate the sharp pains, but helped a little bit. (Tr. 47-48).

When considering both knees, he can stand for 15 to 20 minutes and then must sit down. His back also affects his ability to stand. After 15 to 20 minutes of standing, Claimant has sharp pains in his back running down to his toes. (Tr. 49).

Dr. Gertzbein has not recommended additional active medical care or additional surgery. About two weeks prior to the formal hearing, Dr. Gertzbein advised him there might be "some nerves where the rod is that is pinching." If he does have pinched nerves or nerves wrapped around the rods, the doctor will want to go in and take the rods out. Dr. Stickler wants to deal with this problem before he works on the spinal column stimulator. (Tr. 49-50).

During a typical day, Claimant wakes up at four o'clock in the morning and lies in bed for awhile. He sits and watches television. He lies on the couch until it is time to wake his son for school. He occupies his time during the day by doing puzzles and goes outside to sit or walk around. He has tried to do things around the house, like sweeping and raking, but cannot because it causes his back to hurt too much. His wife and son do all the work around the house. Regardless of the pain, Claimant tries to walk. He goes to Wal-Mart or Target to walk because it is cooler and the floor is level. He can walk better under those circumstances. He cannot walk on his own, but takes one of the shopping carts to relieve some of the pressure on his knees because he leans on the carts while walking. His wife drives him to Wal-Mart or Target for his walks and goes with him every time he wants to walk. (Tr. 51-52, 56).

He tried to drive on his own a couple of times. "Once in a while" he takes his son to school and back or drives three or four blocks to the store. When his wife drives him, he sits in the back seat because the safety belt in the front seat bothers him. When he goes to Wal-Mart or Target, he usually stays there for about one "hour and a half or so. But every other 15 minutes, [he has] to go sit down somewhere." (Tr. 53-54).

Laying down twice a day helps "release the pain" in Claimant's back. He only takes his pain medications "when it gets real, real bad." He takes Tylenol about twice a day, on a daily basis, for his discomfort and pain. His pain medication makes him drowsy so he tries to avoid them. (Tr. 54-55).

Claimant cannot read or write and completed the fifth-grade of formal education. His wife maintains a checking account, but he never writes checks. He cannot write simple notes such as "[g]one to the store." He has tried to learn to read, but "just can't handle it." He has trouble remembering things since his initial injury and subsequent surgeries. He has trouble remembering things people tell him. He did not have memory problems prior to his injuries and surgeries. (Tr. 55-56).

He recalled meeting with Employer/Carrier's vocational expert and testified he gave his "best efforts and abilities" during the vocational expert's testing. He was unable to read anything he was given. He did not think he would be able to work as a ticket taker because he cannot stand for too long and needs to sit or lay down after standing for a short period of time. He did not believe he could alternate between sitting,

standing and moving around for an eight-hour day because he must lie down if he stands up too much.

Claimant also denied he would be able to work as a bench assembler because even though he would not have to lift anything heavy and would be sitting for most of the day, his back hurts while sitting and he would need to lie down to relieve pressure. As to working as a courier, he did not believe he could perform this type of work because he has trouble walking and driving. In addition, he cannot read a map. Claimant also stated he cannot serve food at a cafeteria because it requires too much standing.

As to working retail or as a laser tag attendant, he stated he could not do either because it also requires too much standing and walking. He did not think he could even go out and fill out a job application by himself. Even if a job was found where he can alternate between sitting, standing and moving around, he did not think he could work on a four-hour, part-time basis because he "would have to go and lay down. (Tr. 56-60).

Because he cannot read or write, Claimant's wife always fills out the information sheets at the doctor's office. (Tr. 60).

On cross-examination, Claimant recalled taking a deposition by telephone two weeks prior to the formal hearing. At that time, he testified he had pain in his back and knees, but did not take pain mediation, only muscle relaxers. He testified he only took the muscle relaxers "about once a week" and could not recall when his right knee pain started. (Tr. 61-62).

Although he testified at hearing he has only tried to drive twice, he testified in deposition he drives "about twice a week." (Tr. 62).

Claimant stated he could not sit down for eight hours because he needs to lie down and would disagree with Dr. Bryan if he reported differently. He learned that Dr. Gertzbein wanted to take the rods out of his back after his deposition on September 27, 2004, but Claimant has not submitted any reports about removing the rods to Employer or Carrier. (Tr. 62-63).

He can move his arms and fingers normally. In the past five years Claimant has not tried to work. He receives $722.00 every two weeks or $365.00 per week from workers' compensation. In 1999, Claimant testified he brought home on "average

sometimes 8 or $900.00" per week. He denied knowing that his average weekly wage was $507.00. (Tr. 63-64).

On re-direct examination, Claimant stated he takes medication prescribed by his psychiatrist. He began taking these medications about a week and one-half prior to the formal hearing. (Tr. 65).

Claimant clarified his son usually takes a bus every morning, but one time he was running late and Claimant's wife was still sleeping, so he drove his son to school. He also tried to drive to the store "once or twice, but not very much." Normally his wife does the driving in the family. When Claimant goes to the store to walk once or twice a day, his wife always drives him. She also drives him to church and doctors' appointments. She takes him to every doctor's appointment. (Tr. 65-67).

Rosemary Veles

Claimant's wife, Rosemary Veles, testified they have been married for about 34 years. Mrs. Veles confirmed that she takes Claimant to most of his doctor's appointments. She noticed a change in his emotional status since his original left knee injury. Specifically, he "has been very depressed. At times he is very irritable. He's always just down. His health has really gone down. Most of the time he's just really depressed." She further testified "when he gets panic attacks, it's like – it scares everybody at home." Mrs. Veles compared Claimant's panic attacks to a heart attack and has actually taken him to the hospital a couple of times. (Tr. 67-69).

Mrs. Veles testified, with medication, Claimant's panic attacks do not last as long and he sleeps a little longer. His sleep remains interrupted every night. He wakes up at least twice every night and just walks around the house. He also complains that he cannot breath. After he walks around the house for ten to 15 minutes, he will go right back to bed and sleep for another couple of hours. This happens every night. The house needs to be cold because Claimant gets hot flashes. She did not know if these hot flashes came with the panic attacks. (Tr. 69-70).

Claimant's injury also affects his relationships with other family members. He fished with his son, in the past, but cannot anymore. Because he is "always down with his pain," Claimant no longer socializes. She goes to family gatherings by herself,

but only briefly because she has to go home and check on him. Sometimes she takes her oldest daughter to stay with Claimant. They "try not to leave him by himself because of the panic attacks. He gets them real bad." (Tr. 71).

Their son is in high school band and Claimant tries to go watch him march, but he cannot sit down. Their son has "a lot of concerts and contests all around that [they] used to attend," but now she goes by herself if she can find someone to stay and take care of Claimant. If not, they both stay home and their son tells them how he did. (Tr. 71-72).

According to Mrs. Veles, Claimant has a lot of problems remembering things. She goes to doctor's appointments with Claimant so she can ask him what the doctor said as soon as he comes out of the office. If she waited until they got home, he would tell her he did not remember. She has had to call the doctor's office to get appointments or verify MRIs because he forgets where they send him. (Tr. 72).

Mrs. Veles confirmed Claimant cannot read or write. He cannot go to the store, buy things or make change. Most of the time they use an ATM card, but if Claimant pays, he will turn around and give her the change right away. When they married, she did not know he could not read or write. (Tr. 72-73).

Claimant needs to get off his feet about two to three times during the day. He rests on the couch for about 20 to 30 minutes. He has never gone over three hours without needing to lie flat on his back in bed. (Tr. 73-74).

Mrs. Veles reviewed CX-10, a statement from Hauser Clinic and Associates with a balance pending. She secured the psychiatric care and affirmed that Claimant's private insurance carrier needed to be called to set up the appointments. She also spoke with the insurance company when they suspended care. She testified his private insurance company suspended care because they would only pay for nine visits. After his ninth visit, his claim was denied. Claimant paid a $15.00 co-payment each visit. (Tr. 74-75; CX-10).

She also reviewed CX-11, invoices from Texas Orthopedic collection agency. She has called them directly regarding the bill. Claimant received therapy there after his first knee surgery under Dr. Bryan's direction. She explained to the collection agency that the bills were in connection with a workers' compensation disability claim. She also furnished the

agency with a copy of the prior award letter. Once the bills went to collection, she tried again to get the bills collected directly from the insurance company, but the collection agency advised her that the insurance company "was considered a third party and they would not deal" with the insurance company. The bills have not been paid. (Tr. 76-77; CX-11).

Claimant's credit bureau report, dated July 28, 2004, was received as CX-12 and reflected non-payment of the Texas Orthopedic Hospital bill. Mrs. Veles testified her family has suffered financially because of these credit rating reports. For example, they tried to buy a car because their old truck broke down. They got a very high interest on the car, and the person told them it was because of their credit file. In addition, they recently received a letter from Mastercard advising them that their interest rate will be increased due to their credit bureau file. Mastercard advised her that if a customer falls behind in their obligation they have a right to increase their interest rate. Claimant's outstanding medical bills also affected their ability to get a home equity loan. Their home equity loan was not denied, but was granted "on a higher interest rate because of the credit rating." (Tr. 78-80; CX-12).

Mrs. Veles does "just about everything" for Claimant. She helps him get dressed and bathe. She also does the house chores Claimant used to do, such as changing light bulbs and washing the car. The last time he tried to change a light bulb, he hurt his back and could not move for a couple of hours. He tries to do simple things like sweeping the floors, but it takes him all day and he needs to rest in between. He gets sore after trying to sweep or vacuum. He also tries to make sandwiches for her while their son is in school. (Tr. 80-81).

Claimant has problems being in crowds or around groups. He is not sociable any more and does not even like being around family members. If they have company, he goes to lie down. He is never with company more than 20 to 30 minutes. He will excuse himself to the bathroom or will go sit down and watch television. Mrs. Veles testified he is not happy around crowds and gets depressed all the time. (Tr. 81-82).

The Medical Evidence

Stanley D. Gertzbein, M.D.

Dr. Gertzbein, a board-certified orthopedic surgeon,

testified by deposition. Dr. Gertzbein was deposed in April 2002 and again on September 3, 2004. He is Claimant's treating orthopedic surgeon for his back condition. Dr. Gertzbein performed a "spinal operation [on Claimant on February 28, 2002,] where [he] took away bone and pressure off of the spinal cord at the L4-5 level. That was the level above where he had had his previous surgery. Then we did a spinal fusion at L4-5." (CX-1, pp. 4-6; CX-2, pp. 92-102).

On April 1, 2002, five weeks post-operation, Claimant still had pain. Dr. Gertzbein related the pain to the surgery itself, but Claimant described a burning pain, which is a "red flag." He also mentioned developing panic attacks. Dr. Gertzbein examined Claimant and found his surgery to be healing fine. Dr. Gertzbein was concerned about the pain running down Claimant's right leg and ordered a CAT scan. He also requested a psychiatric consultation because of the panic attacks. Although Dr. Gertzbein admitted he was not an expert in panic attacks, he defined them as "a situation where a patient has a sudden fear of some unknown factor and the heart races and they sweat and they feel like they're under a lot of stress." Dr. Gertzbein found Claimant's panic attacks to be related, in part, to the stresses of surgery. (CX-1, pp. 6-7; CX-2, p. 53).

The CAT scan revealed good positioned screws that were not pressing on a nerve. Dr. Gertzbein concluded something else was causing leg pain, possibly scar tissue. At the end of April 2002, Claimant was well enough to undergo physical therapy to rehabilitate his muscles and stimulate all of the tissues. (CX-1, p. 7; CX-2, pp. 50-52).

Dr. Gertzbein opined "in all medical probability" Claimant will never return to his previous longshore work. (CX-1, p. 8).

After surgery, Claimant slowly progressed. He continued receiving physical therapy, but did not respond well even though he had a solid fusion where the surgery was performed. There are a number of causes of burning pain, but Dr. Gertzbein worried "about scar tissue in the spine, a condition called arachnoiditis." (CX-1, pp. 8-9).

On October 14, 2002, Dr. Gertzbein ordered an MRI to determine whether Claimant had any additional pathology, such as a herniated disk, a bone spur, or arachnoiditis. The MRI revealed he had arachnoiditis present at the surgical levels. Claimant also had additional problems with his left knee. He was limping more and Dr. Gertzbein suspected it was putting

stress on Claimant's back. (CX-1, pp. 9-10; CX-2, pp. 46-47).

Dr. Gertzbein defined arachnoiditis as

> scar tissue inside the spinal cord area and the nerves. It forms because of pathologies of various kinds, and it also forms because of surgery. When scar tissue sets in and is very close to the nerves, as it is in arachnoiditis, it causes constant irritation on the nerve endings, and those nerves end up becoming very, very sensitive even to minimal stimulation. Even bending over or twisting your back in a normal, everyday activity would stir up this scar tissue, which, in turn, inflames the nerves and causes this burning, very unrelenting severe pain . . . it's both a physical fact and a clinical syndrome.

Dr. Gertzbein opined arachnoiditis caused Claimant's continued complaints of burning pain and discomfort and it gets worse with further surgery. (CX-1, pp. 10-11).

Dr. Gertzbein testified there is no cure for arachnoiditis. It is constant and permanent, but there are treatments to help control the pain. He referred Claimant to Dr. Sickler, a pain specialist. Dr. Sickler uses various forms of pain management, including medication, injections, and spinal cord stimulators. To Dr. Gertzbein's knowledge, Dr. Sickler has experience treating chronic pain patients suffering from arachnoiditis. (CX-1, pp. 11-12).

Claimant could not complete physical therapy because of pain. His symptoms are attributable to arachnoiditis and not a psychological magnification. They are physical magnifications. Dr. Gertzbein testified Claimant's limping and knee problems contribute to his back problem. (CX-1, pp. 12-13).

As of February 21, 2003, Claimant had not reached maximum medical improvement. He still treated with a pain specialist. Dr. Sickler gave him epidural steroid injections which only gave him a few hours of relief. When Dr. Sickler's treatment was denied, "in the interim [Dr. Gertzbein] asked him to go back to a physical therapist, review his exercises, and after a session or two with them, to continue on a home program." Dr. Gertzbein also recommended a health club as a less expensive way for

Claimant to participate in a program on his own. A health club membership would provide Claimant with medical benefit because he could participate in basic exercises, use some equipment and have a degree of supervision by a health instructor. (CX-1, pp. 13-15; CX-2, pp. 32-34, 39-43).

He opined that Claimant's complaints of night cramps and problems sleeping are related to his arachnoiditis because "the nerves that are being affected by the scar tissue are irritated and stimulated." Dr. Gertzbein prescribed Flexeril, a muscle relaxer, and "something for sleep." (CX-1, p. 16).

On May 5, 2003, Dr. Gertzbein reiterated Claimant had not reached maximum medical improvement and referred him to a psychiatrist. Claimant was stressed because he was not getting the pain management treatment that Dr. Gertzbein recommended. The stress made Claimant "less able to cope with everyday activities." Depression has been an ongoing problem with Claimant. Whether or not the depression is related to Claimant's work injury, Dr. Gertzbein would defer to the psychiatrist, but from a general observation standpoint, he "thinks it partly contributed to it." In his opinion, Claimant's neck pain is not related to his work injury. (CX-1, pp. 16-17; CX-2, p. 10).

Things went poorly for Claimant for the rest of 2003 according to Dr. Gertzbein. He was not responding to his treatments or various medications. Massage therapy actually aggravated Claimant's problems. Arachnoiditis is not related to posture or positional changes and is not relieved by sitting, standing or lying down. It is "always there, steady, constant, unrelenting, and severe." The type of pain that arachnoiditis gives Claimant is disabling. As of September 3, 2004, Dr. Gertzbein opined Claimant could not engage in sedentary employment. (CX-1, pp. 17-19).

In January 2004, Claimant's condition appeared to worsen. Dr. Gertzbein thought it was in part due to Claimant's knee causing his back to be further irritated. When Dr. Gertzbein examined Claimant, he noticed Claimant's knees were actually swollen. Dr. Gertzbein is a spinal surgeon and does not work on knees. It has "to be pretty big for [Dr. Gertzbein] to see it." (CX-1, p. 19; CX-2, p. 4).

As of Claimant's last visit with Dr. Gertzbein's in August 2004, he was in "very poor condition with respect to his responses to treatment up until this point, and those treatments

run the gambit of medication, physical therapy, injections, and surgery." The complication of arachnoiditis was something no one could have predicted. Dr. Gertzbein opined he did not think Claimant "could do much of anything in terms of employment unless he goes in for another form of treatment that can be used to help people with arachnoiditis, and that's a procedure called a dorsal column stimulator procedure. It works in about 70 percent of patient's with arachnoiditis." If the dorsal stimulator does not work, another possible treatment could be a "morphine pump," which is a constant drip of morphine into the spine. (CX-1, pp. 20-21; CX-2, p. 1).

Dr. Gertzbein opined that Claimant continues to need the benefits of psychiatric care and pain management treatment. (CX-1, p. 22).

Dr. Gertzbein completed a Work Restriction Evaluation form provided by the Department of Labor on August 26, 2004. He noted Claimant had major limitations and should not sit for more than four hours during an eight-hour period. Claimant should not lift, bend, squat, climb, kneel, or twist. He could stand or walk for four hours alternately over an eight-hour period. His lifting restrictions were at the very lowest level, zero to ten pounds, but had no restrictions in his upper extremities. Dr. Gertzbein denied any cardiac, visual, hearing, or temperature limitations. Any problems Claimant had with his family was because he was irritable, which was to be expected. (CX-1, pp. 22-24, Exhibit 3 to deposition).

On the Work Restriction Evaluation form, Dr. Gertzbein indicated Claimant could not work eight hours. Claimant had not reached maximum medical improvement and would possibly need more surgery. As of August 2004, Dr. Gertzbein opined Claimant, because of pain from the arachnoiditis alone, could not work in any capacity, even sedentary. (CX-1, p. 24).

Before Claimant can reach maximum medical improvement, Dr. Gertzbein "think[s] strong consideration should be given to the dorsal column stimulator. There is a better than 50/50 chance that that would work for him. And if it did, then he would reach a certain plateau with that, and then I would say he's reached maximum medical improvement." He would like to see Claimant try this before finalizing his level of disability regarding his back. (CX-1, p. 25).

On cross-examination, Dr. Gertzbein described a dorsal column stimulator as an electric device which "consists of some

electrodes that sit on top of the spinal cord attached to a battery, and the battery emits electricity." The device is implanted under the skin during a surgical procedure. Only the battery needs to be changed about every two to three years, requiring a "minor procedure." The electrode may be changed as well. This initial procedure usually takes about two weeks. (CX-1, pp. 25-27).

Dr. Gertzbein reiterated Claimant had more than a 50 percent chance that the dorsal column stimulator would improve his condition to the extent that Claimant could return to some form of sedentary work. The device is inserted in a one day surgical procedure and results can be seen within a few weeks, such as whether Claimant could return to some sort of employment. The procedure could cost somewhere in the range of $8,000 to $10,000. (CX-1, p. 27).

Dr. Gertzbein admitted less than five percent of patients develop arachnoiditis after the type of surgery performed on Claimant. Not all patients who develop arachnoiditis have severe pain following surgery. On rare occasion, a patient can have this condition without having severe pain. There are different degrees of arachnoiditis based on the amount of scar tissue. Based on Claimant's October 2002 MRI, Dr. Gertzbein opined Claimant suffered from moderate arachnoiditis. (CX-1, pp. 28-29).

Claimant's neck and arm pain are not associated with his work-related injury. Since his surgery at L5-S1, the fusion is solid and the metal is in good position. Dr. Gertzbein opined that if Employer/Carrier wanted to get Claimant back to work they need to have Claimant implanted with the dorsal column stimulator as Dr. Sickler suggested. (CX-1, pp. 29-30).

On re-direct examination, Dr. Gertzbein admitted he would defer to Dr. Sickler's expertise in determining the protocol to follow in pain management. If Dr. Sickler felt that something less invasive than a dorsal column stimulator was the appropriate place to start, Dr. Gertzbein would agree. (CX-1, p. 30).

One of the conditions that develops when scar tissue enters the spinal column and intersects with bundles of nerves, is that "nerve endings will switch so that the touch nerve endings may switch over to the pain nerve endings" explaining Claimant's severe pain to mere touching. The stimulator will not eliminate all of Claimant's pain, but may resolve some degree of the

severity. Even with the dorsal column simulator, Claimant may have pain for 24 hours a day. Based on over 30 years as an orthopedic spinal surgeon, Dr. Gertzbein believed Claimant's complaints of pain were real and did not believe he exaggerated the degree of pain. Moreover, Dr. Gertzbein did not think Claimant was motivated by some secondary gain factor, such as his pending disability claim. (CX-1, pp. 31-33).

William Bryan, M.D.

Dr. Bryan was first deposed on May 20, 2004. He was board-certified as an orthopedic surgeon in 1982 and treated Claimant's knees for several years. As of October 16, 2002, there was no evidence of a meniscus tear in Claimant's left or right knees and his discomfort was "coming from chondromalacia." In addition, as of January 3, 2003, Dr. Bryan opined Claimant was temporarily disabled. He could not state whether it was just as to his knees. Claimant had some back problems, which he did not know everything about, but Dr. Bryan opined between Claimant's spine and knee problems, it was appropriate to give him a "temporary disability placard." (EX-2, pp. 4-5).

On September 3, 2003, Claimant presented with "disabling knee pain." On October 1, 2003, Dr. Bryan recommended a bilateral knee arthroscopy because both the left and right knee MRIs showed grade three medial meniscal tears. From October 2002 until May 2004, there was a change in Claimant's medical condition as to his knees. He observed the meniscus is a load-bearing element of the knee. A torn meniscus does not work as well. (EX-2, pp. 5-7).

Dr. Bryan recommended surgery because the meniscus tears were probably pain generators. Claimant described sharp pain and removal of the torn pieces would relieve some discomfort. Dr. Bryan could not repair the meniscus at Claimant's age. He opined that when the chunks get caught in the wrong places, "it usually leads to discomfort and skewed gait, where they try to avoid the pain by walking in favor of the other leg." One means of correcting skewed gait is to take chunks out. (EX-2, pp. 8-9).

Dr. Bryan indicated if Claimant's seniority was high enough he may be able to carry out many jobs on the waterfront. His opinion was contingent on Claimant having the recommended surgeries; if not, Claimant would less likely be able to return to any form of employment. The recommended surgeries should have improved his ability to perform. According to Dr. Bryan,

without the surgeries Claimant had no hope of performing sedentary work. Claimant would not reach maximum medical improvement until he had these surgeries because "these other problems in his life in many ways overshadow these meniscus problems." (EX-2, pp. 9-12).

Dr. Bryan originally operated on Claimant's left knee in November 2000, and released him as having reached maximum medical improvement in 2001. Claimant returned to treat with Dr. Bryan in the fall of 2002, with complaints that "his knees began flaring up." It was Dr. Bryan's impression that Claimant continued to have pain after his initial release which had gotten worse steadily and persistently. To his knowledge there were no intervening injuries or other medical treatment. (EX-2, pp. 12-14).

The September 21, 2002 left knee MRI, revealed "no evidence of a meniscus tear, grade two chondromalacia involving the weight bearing surface of the medial femoral condyle, grade two chondromalacia involving the medial and lateral patellar facets." His left knee condition was unchanged. Dr. Bryan treated Claimant with another series of injections. At that time, Claimant was still at maximum medical improvement. (EX-2, p. 16).

By January 2003, Claimant had spasms in his legs and other problems in his lower extremity. Dr. Bryan referred him to Dr. Sickler for chronic pain management. Dr. Bryan noted that Claimant walked with a limp which was probably throwing off his back because he was putting additional stress on his spine. (EX-2, pp. 16-17).

In September 2003, both of Claimant's knees were causing problems. He "was favoring his left side, placing additional load on the right side." An MRI was ordered on both knees. There were two major differences between the September 2002 MRI and the September 2003 MRI. Claimant had worn down more of the surface cartilage and developed tears in the menisci. As to the left knee, Dr. Bryan opined the increase in the chondromalacia, as well as the tears in the meniscus were a natural progression of his original injury. Claimant's right knee was symptomatic because he limped and altered his gait, putting more pressure on it. Dr. Bryan also opined that limping and the altered gait exacerbated or accelerated Claimant's right knee condition. His problems were not the result of mere deterioration with age. (EX-2, pp. 18-20).

Dr. Bryan proposed performing arthroscopic surgical procedures for both knees to alleviate Claimant's pain and discomfort. Tears in the meniscus "are probably giving rise to some sharp, stabbing pain, and the goal is to eliminate" those pains. The procedures will not change Claimant's post-traumatic arthritis which has developed in both knees nor his functional capability, physical limitations and impairment. He opined that the additional knee surgeries will not enhance Claimant's ability to return to his former employment, but, if recovery goes well and the pain generation problems are resolved, Claimant should be able to do some type of sedentary work. (EX-2, pp. 21-23).

Dr. Bryan was re-deposed on October 14, 2004. He performed arthroscopic surgery on both knees on June 7, 2004, and followed-up on June 11, 2004. The arthroscopy revealed "right knee medial and lateral meniscus tears. Within his left knee there were areas of chondromalacia which deserved debridement." Dr. Bryan opined that with rehabilitation Claimant could return to sedentary work only by August 1, 2004. (EX-5, pp. 4-5).

On July 2, 2004, Dr. Bryan reported "[t]he arthroscopic brought significant pain relief to [Claimant's] right knee. Physical therapy has been quite happy with his progress." Claimant was able to walk with minimal gait support. Dr. Bryan concluded Claimant could expand his activities and build much needed leg strength. (EX-5, p. 5).

Claimant's knee function improved and Dr. Bryan believed that by August 2004, he could make a statement about maximum medical improvement. He was certain that with the post-traumatic and degenerative condition he observed in Claimant's knees that he would be able to do no more than stand three to four hours a day when he returns to work. Claimant had a flare-up of synovitis on August 18, 2004. Dr. Bryan injected the right knee with 80 milligrams of Depo-Medrol. Claimant used a cane to walk and would need to use one for another week or two. (EX-5, p. 6).

Dr. Bryan completed a Work Restriction Evaluation form on August 24, 2004, regarding Claimant's knees only. He did not take Claimant's back condition into account. His notations that Claimant could sit for eight hours a day and walk for two hours were based only on Claimant's knee injury. Although Dr. Bryan checked off Claimant had a lifting restriction of 20 to 50 pounds, he meant to check off the 10 to 20 pound restriction. Dr. Bryan opined Claimant "could probably work four to six hours

a day at most as of October 2004." Regarding Claimant's left knee, he could work eight hours a day, sedentary only, if his right knee and back conditions are not considered. If his right knee, back and other problems were combined, he would not be able to work a full eight-hour day. As to the right and left knee, Claimant could work eight hours a day at sedentary work only. Dr. Bryan further indicated Claimant had reached maximum medical improvement. (EX-5, pp. 6-9).

According to Dr. Bryan, Claimant's right knee problems are related to his original injury. His opinion remained unchanged even after surgery was performed. His opinion was based on his observations on changes that appeared "to be that of a knee . . . that's been overloaded because he's been trying to get off the problem on his left side, overload the right. [Dr. Bryan] saw a combination of torn cartilages and damaged joint surface as a result of that." Dr. Bryan anticipated Claimant, over the next four to six years, would benefit from a series of joint fluid therapy injections to the knee, but they would stop being effective and Claimant would need a total right knee replacement. (EX-5, pp. 9-10).

Although Dr. Bryan never personally examined Claimant's spine, he admitted Claimant's lumbar problems, which could not be taken out of context, probably add to his knee problems. Claimant moves with a stiff, sore back and uses his legs to get up and turn and twist. He overloads his knees in that respect. In addition, the nerves carry impulses down and up. Dr. Bryan was "not sure he's getting all the impulses down to his muscles to fire them off. So it could be he could have some weakness in his legs." Given Claimant's knee condition, when he tries to walk and do other things, it aggravates his back problems. (EX-5, pp. 12-13).

In determining functionability, there was no way to "separate his aggravated knee problems from the surgeries and their de-conditioning from his back problems" according to Dr. Bryan. It is reasonable for Claimant to recline for about an hour each time he performs activities, such as walking around in the house or mall, to relieve the pain in his back and knees. Dr. Bryan also believed standing is a function that will aggravate Claimant's knee problems. (EX-5, p. 13).

Dr. Bryan admitted he was a "bit over-optimistic when [he] saw him those first two visits . . . because [he] saw [Claimant] for the last time on 9-22-04, and he's having more problems with synovitis and swelling in his knees than [he] would have

anticipated." On September 22, 2004, Claimant reported "with vague complaints of pain in and around his knees. On further questioning, [Claimant reported] he has more leg pain than knee pain, which is hampering his functional activities." At that time, Dr. Bryan strongly advised Claimant to seek a consult from his spine surgeon. Again, he could not separate Claimant's knee function from his back and "to optimize a difficult situation with his knees, [then have to] optimize his spine situation." (EX-5, pp. 14-15).

Dr. Bryan received two separate letters from Dr. Stokes, the vocational expert. The first letter described the bell ringer job. Dr. Bryan opined that from his knee perspective, Claimant could perform this job. The second letter described six or eight jobs, with five of them just not plausible because they involved some climbing, squatting and lifting loads. Given his last visit with Claimant and considering that his knee swells and he has pain in his back, Dr. Bryan did not think Claimant, in his present condition, could work for an eight-hour time period, even if alternating between sitting and standing. In addition, if a job included even walking upstairs, such as the laser tag attendant job, Claimant could not do that job. With his knee condition, he would have difficulty climbing stairs. If Claimant just had knee problems, he might be able to perform the seasonal job as a bell ringer with the Salvation Army. However, if Claimant's knee and back problems are included, he could not perform the bell ringer job. (EX-5, pp. 15-17).

Dr. Bryan did not know an exact AMA guideline impairment percentage for Claimant's knees, but approximated 20-percent impairment of each extremity. (EX-5, pp. 18-19).

Robert Sickler, M.D.

Dr. Sickler, a board-certified anesthesiologist and a Fellow of the American Board of Pain Management, was deposed on March 30, 2004. He performs "interventional techniques within the scope of an anesthesiologist. Interventional techniques can be

> injections in the office into muscles or ligaments or joints . . . injections around nerves both for diagnosis or treatment, spinal injections, implantation of devices for the control of pain, such as spinal cord stimulators implantable drug pumps, ablation

> procedures to nerves where we try to destroy the nerve to provide long term pain control.

It is not part of his practice to perform procedures such as laminectomies, discectomies, or spinal fusion. (CX-5, pp. 7-8).

Claimant first treated with Dr. Sickler on December 9, 2002. Dr. Sickler was aware Claimant had a prior L-5 fusion and considered that relevant in forming his opinion at the time of his initial evaluation. About 20 to 25 percent of his practice consists of workers' compensation patients. Claimant was referred because of chronic knee and back pain. (CX-5, pp. 17-20).

Dr. Sickler reviewed Claimant's medical records, including recent diagnostics. He also obtained a medical history from Claimant. Claimant presented "complaints of both back and lower extremity . . . pain that radiated from his back to the top of his foot with persistent numbness on the left side." He described a 50/50 back to leg ratio, indicating half the pain was in his back and the other half in his leg. They also reviewed Claimant's medication history, specifically how much Opiates he was taking on a daily basis. (CX-5, pp. 20-23).

On physical examination, Claimant had "a fair amount of guarding with significant decrease in range of motion essentially in all plains . . . He was also very tender over some small joints on the backside of the spine above the level where he had had his previous surgery." Physical examination also revealed Claimant had good strength in his lower extremities. He had some discrepancy to sensation to light touch along the L-5 dermatone on the left. His deep tendon reflexes were also somewhat decreased on the Achilles when compared to the patella. (CX-5, pp. 24-25).

Dr. Sickler also noticed spasms through palpation. He felt tension in the muscle. There was no reason to believe Claimant was feinting his range of motion measures. Serial measurements help determine whether someone is exaggerating his symptoms, but he did not feel it was necessary to perform this test on Claimant. Tenderness in the facet regions was determined by palpating the area. Claimant complained of pain with pressure over those structures. Pain is a subjective experience and he relied on Claimant's responses. He did not do specific tests to measure Claimant's pain levels. A patient can usually not suppress a reaction to a reflex test if distracted, but Dr. Sickler did not feel he needed to distract Claimant. (CX-5, pp.

26-30).

As of Claimant's initial visit, Dr. Sickler opined he suffered from "vertebrogenic low back pain, some muscular dysfunction second to that, arachnoiditis, and some arthralgia of the left knee." He relied on the report of the MRI and not the films themselves. Arachnoiditis is the scarring around the nerve roots of the spine. Arthralgia could result from strain or inflammation in his left knee. "Arthralgia simply means pain, painful joint." (CX-5, pp. 31-32, 35-37).

Claimant underwent epidural steroid injections with Dr. Gertzbein at River Oaks. Claimant may not have received relief because of the scarring around the nerve roots where the medication could not penetrate the segmental level. (CX-5, pp. 33-34).

Dr. Sickler opined the arachnoiditis likely developed as a reaction to Claimant's surgery. He would need to see post-2002 surgical MRIs before forming an opinion as to whether these problems resulted after the 1984 surgery or after the 2002 surgery. (CX-5, pp. 37-38).

Dr. Sickler recommended continuation of some medication management to pinpoint possible factors that were contributing to Claimant's ongoing pain through a selective injection of the facet joints at the level above his surgery. According to Dr. Sickler, Claimant's pain is directly related to the levels above his previous fusion because he cannot bend at L4-5 or L5-S1 any longer. Claimant presented with ongoing back pain, which Dr. Sickler related to overwork of the L3-4 segment. Dr. Sickler stated this could account for slippage of one vertebrae on top of another, because overuse of a segment can break down the segment. Claimant's physical examination was consistent with segment breakdown, therefore he suggested an injection at L3-4 to pinpoint if that level was contributing to his ongoing symptoms. (CX-5, p. 39).

To determine how much, if any, of the degenerative changes were present before the 1999 accident or between 1999 and 2002, Dr. Sickler needed to see studies for those periods. He knew Claimant underwent surgery and injections into the disk, but had not reviewed those studies. He could only presume that L3-4, was not a provocative level at the time that surgery was contemplated. (CX-5, p. 40).

Claimant's L5-S1 level is responsible for 75 percent of his segmental motion in his lower back. As the level gets fused, it begins to put more strain on the level immediately above it. His fusion in 1984 caused greater strain to be placed on the L4-5 and L3-4 levels. Engaging in heavy labor or activity could accelerate the process even more. As a general rule, the more one uses one's spine the more the degenerative process accelerates. The average length of time between a fusion and subsequent surgery is about ten to 15 years. (CX-5, pp. 41-42).

Dr. Sickler performed several facet injections at L3-4. He used a fluoroscopy, a computerized x-ray that gave him a live television view of the x-ray, which helps him be very specific in the placement of the needle into the facet joint. He put two types of medication into the L3-4 level. He also used a corticosteroid, a Cortisone-like medicine into the joint. The injections were made directly into the joint. (CX-5, pp. 42-45).

The epidural steroid injections provided no relief because the scar tissue prevented the anesthetic or the analgesic portion of the injection from actually getting to the nerve root. Dr. Sickler was concerned with the primary source of the pain even though chronic back pain is often multifactorial. He was not going to be effective treating the arachnoiditis. Based on the physical examination, he opined the major culprit in causing Claimant's back pain was likely associated with the joints on the backside of the spine, not the nerve roots. (CX-5, pp. 45-46).

On January 20, 2003, he injected the lumbar facets and saw Claimant back in his office on January 27, 2003. Claimant reported improvement in his symptoms for six to seven hours after the procedure, then the pain returned. Dr. Sickler did not treat Claimant again until May 6, 2003. His diagnosis and recommendations remained unchanged. Dr. Sickler performed a dorsal median branch block on June 2, 2003, from which Claimant received about seven hours of relief and then returned to baseline pain. Dr. Sickler opined the joints contributed to his lower back pain. It took about two weeks for Claimant's back to return to the same pain as prior to these procedures. (CX-5, pp. 46-50).

Because the procedures provided temporary interruption of pain, Dr. Sickler suggested an ablation procedure called radiofrequency where he cauterizes the nerve. He performed this procedure on October 6, 2003. Claimant followed-up on October

21, 2003, and reported about a 30 percent overall improvement in lower back pain. Dr. Sickler observed Claimant had difficulties simply walking. He walked slowly and with a guarded gait. He never saw Claimant walk normally or without pain. (CX-5, pp. 50-53).

Claimant's follow-up visit showed ongoing problems with the paraspinal musculature. Dr. Sickler performed trigger point injections on November 18, 2003 and December 4, 2003, but Claimant did not tolerate them well. He had hypersensitivity in the paraspinal area. Dr. Sickler suggested percutaneous neuromodulation treatment (PNT). He performed four treatments and Claimant indicated initial relief, but Carrier suspended treatment. Dr. Sickler noted that Claimant moves and behaves like a chronic pain patient. (CX-5, pp. 54-57).

Dr. Sickler is familiar with secondary gain and understood Claimant had an ongoing compensation claim. Dr. Sickler never referred Claimant for psychiatric treatment because he was already treating with Dr. Hauser, a psychiatrist, for anxiety and panic attacks. (CX-5, pp. 58-61).

Dr. Sickler would like a psychiatrist to determine whether any other factors are causing Claimant to suffer. He noted evidence of ongoing depression and severe adjustment disorder following Claimant's injury and surgeries. Dr. Sickler's ultimate goal is to get Claimant into a comprehensive pain and rehabilitation program which includes rehabilitation and psychiatry. Presently, Claimant is "so debilitated" he would fail in such a rehabilitation program. Dr. Sickler's goal is to improve Claimant's physical pain in order to send him to a program that will address his emotional pain and reconditioning. (CX-5, pp. 64-65).

Dr. Sickler did not perform an MMPI or any other psychological tests. His diagnosis of adjustment disorder was premised on his own personal observations. Dr. Sickler admitted he was not an expert in psychiatry, but, in connection with their complaints of pain, he does perform psychotherapy and treats psychological or psychiatric disabilities every day. He has never testified in deposition that any of his patients presented malingering or secondary-gain motivation. (CX-5, pp. 65-68).

Dr. Sickler could not render an opinion when Claimant would reach maximum medical improvement. He recommended "entrance into a comprehensive pain rehabilitation program which would

involve psychological testing, physical evaluation, a functional capacity evaluation, and a determination for treatment options based on those further evaluations." Once psychologically stabilized, Dr. Sickler would consider a percutaneous trial of spinal cord stimulation. He would "place some electrodes above the level of Claimant's injury and stimulate those areas electrically along the spinal cord to block the pain signals as they travel through the cord to the brain." The purpose of this procedure would be to cause a physical interruption of the pain signal. To date, Dr. Sickler had not issued a report recommending any comprehensive pain treatment program, psychiatric treatment or psychological treatment. He has not made such recommendations because they were in the process of percutaneous neuromodulaton treatments and he would rather perform less aggressive procedures. (CX-5, pp. 68-71).

He last treated Claimant on January 27, 2004, because workers' compensation would not authorize additional treatment. He did not know whether Claimant has treated with any other doctor within the last 60 days. Dr. Sickler's administrative assistant, Itzel Conseco, advised him that additional visits were denied. It is her ordinary practice to make notes regarding a phone call to a compensation person to reflect whether they denied or approved treatment. (CX-5, pp. 72-74).

The comprehensive pain management program would likely last about eight weeks after which a functional capacity evaluation is usually performed. This program costs about $40,000.00 and should give Claimant more constructive ways to manage his chronic pain. In addition, it could help control his depression and increase his ability to participate in more activities of daily living. If Claimant still needed treatment after completing pain management, Dr. Sickler recommended spinal cord stimulation, but only if Claimant was no longer depressed. (CX-5, pp. 75-77).

Dr. Sickler opined Claimant cannot return to work in any capacity, not even sedentary work. Without a functional capacity evaluation, Dr. Sickler could not objectively measure restrictions on Claimant's activities, but "would imagine it would be quite limited." Claimant was totally disabled when he first saw him and remains in substantial pain. (CX-5, pp. 78-79).

On cross-examination, Dr. Sickler stated for continuation of Claimant's treatment he would pick up from the PNT therapy because it is the most conservative approach. The series

usually takes about five to six weeks doing ten to 12 sessions "to serially stimulate, sequentially stimulate those nerve root endings so that we can achieve desensitization." Arachnoiditis "could lead to alternations in the way that the nerve signals are sent or transmitted through the central nervous system." His goal is to reverse the activity and provide Claimant with an opportunity to become more active. Dr. Sickler testified that function was the goal, not necessarily pain relief. Claimant would be starting the whole regimen over again because there has been a three month lapse in treatment. (CX-5, pp. 80-81).

"Arachoiditis on an MRI scan appears as scarring or clumping around the nerve roots . . . there is also scarring within the nerve roots," Dr. Sickler opined that what was once a normal touch has now become a painful touch. PNT therapy or spinal cord stimulation attempts to quiet some of those changes, which is why he recommends PNT therapy immediately. Arachnoiditis explains Claimant's oversensitivity to touch. With the PNT therapy, he would try to restore the balance, but with spinal cord stimulation, he would actually try to stimulate the good fibers at the level above thereby limiting the ability of the painful signals to get through. (CX-5, pp. 82-84).

Dr. Sickler did not have an opinion as to whether Claimant was involved in secondary-gain issues or malingering with his injury. In his practice and treatment of thousands of patients, Dr. Sickler stated he has the ability to determine whether or not a patient exhibits signs of exaggerating symptoms and secondary gain. He never felt the need to test Claimant for those types of factors because his interactions with Claimant never indicated secondary-gain issues. He recommended a psychological evaluation because of Claimant's situational depression and anxiety, not for secondary gain issues. (CX-5, pp. 85-87).

Dr. Sickler clarified the focus of his treatment has primarily been to Claimant's lower back. Claimant's continuous knee pain was overshadowed by his back pain. Dr. Sickler did not treat Claimant's knee pain because Claimant had a separate orthopedist treating his knees. (CX-5, p. 89).

Dr. Sickler detected muscle spasms in different areas of Claimant's back and on his left trapezius. Claimant's physical examination corroborated his descriptions of subjective pain. There was nothing in any examination suggesting exaggeration or faked responses. Examination also revealed mild fascial dysfunction which causes atrophy within the muscles with tender

areas or trigger points that represent areas of persistent contracture even though other areas are periodically relaxed. The trigger points in the myofascial dysfunction also added to Claimant's physical limitations and pain and were objective signs of his injury as well. (CX-5, pp. 90-93).

Throughout the course of treatment, Claimant was a cooperative patient. He submitted to any treatment mode or recommendation made, even when uncomfortable. Although there was a gap of treatment from January 27, 2003 until May 2003, Dr. Sickler blamed Carrier for refusing to authorize additional treatment. He opined that when treatment is delayed for a four-month period the chance of success, particularly in chronic pain, is lessened. Dr. Sickler testified this delay was not helpful for Claimant psychologically. (CX-5, pp. 94-95).

When Claimant returned in May 2003, physical examination revealed taught bands and areas of trigger points on the left side. Claimant remained tender over the lumbar facets. "[P]ain was increased with extension of the lower back, a common finding in individuals who have facet dysfunction." Dr. Sickler had no reason to believe Claimant's complaints were not true based on his physical examination. (CX-5, p. 96).

Dr. Sickler performed ablation on an outpatient basis. This was done two levels above Claimant's injury site and was a success, providing 30 percent relief. Despite having a successful ablation of the branch nerves, Claimant still had trigger points. Dr. Sickler observed that it is not likely the arachnoiditis would spread to the level above Claimant's fusion. (CX-5, pp. 98-101).

The mechanical changes in Claimant's lumbar spine make it physically impossible for him to return to the level of activity required of a longshoreman. Dr. Sickler opined Claimant could not participate at any level in an eight-hour work day. Although Claimant had surgery in 1984 with fusion of L5-S1, he functioned as a longshoreman for many years without limitation. He then developed an injury that required surgical stabilization. The surgery did not help and Claimant developed ongoing pain problems directly as a result of that injury. Claimant developed degeneration and breakdown of the level above the fusion. Dr. Sickler further opined, based on reasonable medical probability, Claimant's current situation is associated with his injuries and subsequent care of his 1999 work injury. In addition, with motion, "strain is placed on the supporting structures and paired joints, the facet joints, of the back of

the spine" resulting in inflammation and hypertrophy of the joints. Dr. Sickler stated Claimant has hypertrophy and inflammation in his facet joints. (CX-5, pp. 102-106).

Dr. Sickler could not opine what Claimant's permanent back condition will be because he hoped treatment would allow Claimant to become more active and reduce his pain. Dr. Sickler denied having any information that the arachnoiditis existed prior to the 1999 knee injury. He was also unaware that there was a 20-month delay between the time of Claimant's knee injury and his first back complaint. If Claimant complained of knee pain, Dr. Sickler would have sent him to the orthopedist treating his knee, but would not have made a notation in his records about any other complaint, other than directly relating to his back. (CX-5, pp. 106-108).

Dr. Sickler related Claimant's inability to work to his back and did not render an opinion about Claimant's knees. As to Claimant's psychological condition, he would defer to a psychiatrist or psychologist as to the diagnosis and opinions with respect to the cause of those conditions. (CX-5, p. 108).

Dr. Sickler could not state that Claimant's first surgery in 1984 did not result in arachnoiditis. However, Claimant was not having any major symptoms until his injury in November 1999, while working on a full-time basis as a longshoreman. Given this history, Dr. Sickler affirmed it is not probable that he developed arachnoiditis after the first surgery. (CX-5, p. 109, 111-112).

At the time of his deposition, Dr. Sickler recommended another round of PNT in conjunction with pain treatment. He would like the evaluation for the program and implementation of PNT because that provided Claimant temporary relief. If he can do anything to improve Claimant's position before he enters a program, he will be better off and have a better outcome. (CX-5, pp. 109-111).

Robert A. Fulford, M.D.

Dr. Fulford, a board-certified orthopedic surgeon since 1967, testified by telephonic deposition on September 27, 2004. Per Employer's request, he conducted a medical examination on September 15, 2004. He also evaluated Claimant on December 11, 2001 and February 17, 2004. He had the opportunity to review all of Claimant's medical records, x-rays and MRIs. Claimant informed him of his 1999 work accident and also related his

subsequent medical treatment and surgeries. Claimant advised Dr. Fulford that all of his activities were limited and he could not sit, stand, or walk for more than one-half hour. (EX-8, pp. 5-6; EX-7, p. 1).

On physical examination, Claimant appeared to be in no apparent distress, but was constantly leaning toward his right. As the interview progressed, Claimant did not show any evidence of significant distress and could raise himself from the examining chair without any apparent difficultly. Claimant walked "with what appeared to be a painful or antalgic gait on both the left and right side." Dr. Fulford noted Claimant's spine showed a well-healed surgical incisional scar in the midline and on the right and left side over the iliac crest. (EX-8, p. 7).

Claimant exhibited great pain bending forward and could only reach his fingers to the upper thirds of his tibia or his leg bones. He could not extend more than a few degrees because of his pain. Physical examination also revealed a gross limitation of lateral bending to the right and left and pain when rotating from left to right. Examination of his knees showed no effusion, swelling, or water on either the right or left knee. There was no thickening of the lining of the joint or synovial thickening and there was no significant postural thickening, but if Dr. Fulford touched almost anywhere on the knee, it "apparently caused an exquisite painfulness, painful to the lightest touch." (EX-8, p. 8).

Dr. Fulford conducted a McMurray test, designed for the integrity of the cartilages or the menisci, but was fraught with muscle guarding and great pain. Thus, Dr. Fulford abandoned the test. Attempts to do the drawer sign, Lachman or pivot shift tests were also met with muscle guarding and apparent great discomfort. Those tests were designed to assess the integrity of the cruciate ligaments. Consequently, Dr. Fulford also abandoned those tests. (EX-8, p. 9).

The pinwheel sensory examination revealed decreased sensation, especially in the left lower extremity from groin to toes. Dr. Fulford testified there was no physical basis for that type of loss of sensation and was a sign of symptom magnification. Claimant showed "a number of positive Waddell signs such as superficial tenderness to the lightest touch in both lower extremities, to his abdomen, to his low back, around his knees, and even on the soles of his feet." According to Dr. Fulford, the Waddell signs taken with the remainder of the

examination indicated symptom magnification. (EX-8, pp. 9-10).

Dr. Fulford testified that the arachnoiditis could explain the exquisite tenderness in the lower back, but would not in the abdomen and upper back. Claimant also showed apparent great weakness of the extensor hallucis longus, the big toe, muscle tendon that straightens the toe out. This was inconsistent with his earlier ability to raise his body weight on his heels, which indicated strong, good dorsiflexors. "Throughout the sensory and motor testing he did show disproportionate responses of verbalization and facial expressions . . . demonstrated symptom magnification." (EX-8, pp. 10-11).

It was Dr. Fulford's impression that Claimant had degenerative lumbar disk disease due to genetics, lifestyle, and age. He did not believe it related to the November 1999 left knee injury. Claimant also demonstrated degenerative disease of both knees. Dr. Fulford thought "there was marked functional overlay and multiple positive Waddell signs of symptom magnification." Functional overlay is another form of malingering. (EX-8, p. 12).

Dr. Fulford stated Claimant's knee and back conditions would not keep him from performing sedentary work for 8 hours per day, 40 hours per week. Dr. Fulford concluded Claimant could perform at least sedentary work. (EX-8, pp. 12-13).

Dr. Fulford opined Claimant had reached maximum medical improvement as to his knees. As to his back, Dr. Fulford stated Claimant is not likely to improve over the next year or foreseeable future. Dr. Fulford found Claimant was at maximum medical improvement for his back as well. (EX-8, p. 13).

He would not relate Claimant's right knee problems to his left knee injury. Dr. Fulford testified he was not qualified to talk about whether the panic attacks related to Claimant's work injury, but admitted he has performed this kind of surgery on patients and to his knowledge none of the patients developed panic attacks after surgery. (EX-8, p. 14).

Dr. Fulford reviewed the October 2002 lumber MRI, and observed arachnoiditis which is not an unusual condition after surgery. Arachnoiditis may cause patients to have chronic pain. Dr. Fulford did not think it would preclude Claimant from ever doing sedentary work. According to Dr. Fulford, arachnoiditis shows irritability of the nerves and may affect the feeling of light touch, but it should be in the dermatome patterns, which

in Claimant's case it was not. Dr. Fulford explained that anatomically where Claimant had pain to light touch was not consistent with arachnoiditis nerve problems. He noted there is no objective test to determine whether Claimant has chronic pain. It is difficult to separate the brain and the body and Dr. Fulford acknowledged that if you have pain for a long period of time, your brain gets used to that and may make you think you have pain when you do not. There is a certain amount of psychological overlay that is experienced in people who have chronic conditions. (EX-8, pp. 14-17).

Dr. Fulford agreed with Dr. Sickler "that attempts could be made to help [Claimant] obtain more comfort[,]" but was not sure that it would be successful. Accordingly, he left the pain management recommendations to the pain management experts. (EX-8, p. 17).

On cross-examination, Dr. Fulford acknowledged evaluating Claimant on December 11, 2001, February 17, 2004 and September 15, 2004. During the December 2001 examination, Dr. Fulford noticed Claimant muscle-guarded his knee, but he did not have pain due to light touch. There was also muscle guarding in February 2004, but he did not record light touch. The muscle guarding was seen throughout each examination, but light touch pain was only seen during the September 15, 2004 examination, as a new finding. (EX-8, pp. 18-19).

During the September 15, 2004 physical examination, Claimant was absent an ankle jerk. Dr. Fulford got a response on the right side, but no matter what he did, he could not get a response on the left side which indicated significant nerve damage on the left side, probably the right side too because it was not a normal reflex. Dr. Fulford opined that Claimant exhibited symptom magnification during each examination. (EX-8, pp. 19-21).

Symptom magnification involves a response greater than expected. Claimant would not relax or allow Dr. Fulford to examine him. He advised Dr. Fulford that he saw Dr. Sickler on September 14, 2004 and "you doctors like to hurt people." Claimant feels that doctors are there to elicit pain. (EX-8, pp. 21-22).

Dr. Fulford observed Claimant walking and his gait was not normal and noted "[i]n the literature there's no substantiation that a limp causes back problems." Dr. Fulford would not state he never experienced patients who had bad gait or limping

develop back pain, but reiterated the literature did not substantiate it. (EX-8, pp. 23-24).

Dr. Fulford acknowledged Dr. Gertzbein treated Claimant more often then he did and therefore, probably had a greater opportunity to observe Claimant. People with Claimant's type of physical problems likely have good days and bad days, "[s]o some days his limp may be worse than others, and some days his back may be more problematic than others." Dr. Fulford considers Dr. Gertzbein an honest doctor with a good reputation. According to Dr. Fulford, Dr. Sickler also has a good reputation, for pain management, in the medical community. (EX-8, pp. 24-27).

Dr. Fulford admitted he was not qualified to talk about the "switching of nerves and their functions." He had a problem using that as an explanation for Claimant's sensitivity to touch because when he did measurements of the extremities, he was not seeing the amount of wasting or inappropriate reduction in muscle mass over the years. Comparing 2001 measurements with the 2004 measurements, Claimant appeared to have more muscle mass. Dr. Fulford did not think Claimant was having as much problems ambulating as he indicated – another sign of symptom magnification. Dr. Fulford was not aware of Dr. Gertzbein's opinion that Claimant was not exaggerating his symptoms, but stated none of his treating physicians conducted Waddell tests. Dr. Fulford stated "if you don't look for [symptom magnification], you don't find it." Accordingly, Dr. Gertzbein and Dr. Sickler may have "missed the boat." (EX-8, pp. 28-29).

Dr. Fulford has had patients treated at Dr. Sickler's pain management clinic which was usually thorough and helpful. Pain cannot be measured and is subjective. Dr. Fulford opined Claimant was having far more pain than he would expect in inappropriate spots. He acknowledged there is no cure for arachnoiditis. (EX-8, pp. 29-31).

Dr. Fulford reviewed the operative reports from both knee surgeries in June 2004. Claimant's left knee arthroscopy was a cleanup operation. Dr. Fulford performed this "cleanup" surgery many times before as an attempt to relieve some arthritic-type pain in the knee. (EX-8, pp. 32-35).

As to Claimant's right knee, Dr. Bryan's post-operative diagnosis included complex medial meniscal tear, grade 3 patellar femoral chondromalacia, a general reactive sinovitis, and a grade 2 medial femoral chondromalacia. Dr. Fulford opined because there was no history of any injury to the right knee

other than excessive or extra force, the tear was due to degenerative changes. He denied that excessive or extra force would cause a torn meniscus, stating that there is "nothing in the medical literature that suggests that extra stress on a knee, limping or a short leg, causes degenerative changes. (EX-8, pp. 35-36).

Based on both knees, Dr. Fulford restricted Claimant from climbing stairs or kneeling, but thought walking would be good for him. Claimant would need periods of rest. Stair climbing and kneeling would put excessive, undue strain on Claimant's knees and should be avoided. Claimant should not jog. (EX-8, pp. 36-37).

In relation to Claimant's back condition, Dr. Fulford stated "if you don't use it, you lose it. . . . Even a herniated disk may get better with action and movement and therapy. So [he thinks] movement is good." Claimant could not work as a longshoreman, but could do menial tasks that would allow him to sit, stand, or move. Claimant informed Dr. Fulford that he needs to lie down to get rid of pain. He opined this makes it sound more like Claimant has spinal stenosis and nerve problems, which fits with the arachnoiditis and the scarring. (EX-8, pp. 37-39).

Dr. Fulford needed a standard x-ray of Claimant standing and a recent bone x-ray to determine if Claimant's left knee is worse than when he was initially examined. (EX-8, p. 39).

According to a study by Dr. Mosley, one of Dr. Bryan's colleagues, arthritic knees will not benefit from arthroscopic surgery. In Dr. Fulford's opinion, Dr. Bryan treated Claimant as if he was not a workers' compensation patient. He treated Claimant more for his pain and attempted to give him some relief. (EX-8, pp. 40-43).

The mere fact that Claimant had previous surgery and a labor intensive job probably accelerated degeneration in the knees. Dr. Gertzbein operated at L4-5 and the report indicated a lot of scarring which indicated prior surgery at the same location. Dr. Fulford opined scarring down in and around the nerve roots does not come from excessive wear and tear above an old fusion, it indicates actual surgery. Dr. Fulford concluded Claimant's back condition was materially and substantially greater because of his prior back problem. (EX-8, pp. 44-45).

Dr. Fulford agreed that the MRIs of the right knee showed a torn media meniscus and Dr. Bryan was obligated to correct that. As such, Dr. Fulford did not have a problem with the right knee surgery. As to Claimant's left knee, Dr. Bryan had "already been there, done that." If he missed something, however, Dr. Fulford admitted it was reasonable for him to go back and look. (EX-8, p. 46).

Donald E. Hauser, M.D.

Dr. Hauser, a board-certified psychiatrist since 1989, was deposed on October 4, 2004. Dr. Hauser first treated Claimant on April 18, 2002, for complaints of panic attacks which developed after his surgery. He was aware of Claimant's work accident, but did not recall any specifics. He knew that Claimant was out of work for about three years because of his accident. (EX-9, pp. 4-6).

Claimant reported his first anxiety attack started days after surgery. He could not breathe. He would sweat and have increased heart rate, usually at night. He also reported difficulty sleeping. He accounted for several panic attacks in a given day. Claimant had feelings of helplessness, but no suicidal thoughts. Dr. Hauser's initial impression was a panic disorder and to rule out depression. He placed Claimant on Paxal and PRN Xanax and scheduled a follow-up appointment in three weeks. (EX-9, pp. 6-8).

Claimant returned to Dr. Hauser on May 9, 2002, and reported feeling a "little bit better." He still had anxiety, but less often. Dr. Hauser increased Claimant's Paxil, continued the Xanax as needed and ordered a follow-up in six weeks. (EX-9, pp. 8-9).

Six weeks later Claimant had decreased panic attacks, but felt desperate and frustrated. He participated in physical therapy and reported the pain was not bad if he did not overdo it. He had headaches and saw his cardiologist, Dr. Mullins, who informed Claimant he was having anxiety. Claimant still has not taken the prescribed Xanax and did not report any side effects to the Paxil. He occasionally had choking sensations. Dr. Hauser reported Claimant was less anxious but a little dysphoric with helplessness and increased his Paxil to 40 milligrams. He advised Claimant to follow-up in four weeks. (EX-9, p. 9).

Claimant returned on August 12, 2002, and presented with anxiety, irritability and frustration. The panic attacks were

better overall, but his sleep had declined. He described daytime drowsiness. Dr. Hauser did not change his medication, but added BuSpar twice a day up to 15 milligrams. (EX-9, pp. 9-10).

On September 23, 2002, Dr. Hauser noted the BuSpar made no difference. Claimant reported terrible sleep and shortness of breath. Starting January 30, 2003, Dr. Hauser began tapering Claimant off Paxil, continued his BuSpar and added Remeron. The panic attacks were better, but there was residual anxiety and depressive symptoms. Claimant did not show for his next appointment on March 20, 2003. (EX-9, pp. 10-11).

Dr. Hauser did not treat Claimant again until September 10, 2004. Claimant reported no change in his symptoms, but explained he had not returned for additional treatment since January 30, 2003, because the Remeron made him feel good. Claimant informed Dr. Hauser he could not do much secondary to his knees and back because if he stood too long his back hurt and if he sat too much his knees hurt. He also described panic attacks, lasting anywhere from one minute to hours and occurring one to two times per week. They were usually precipitated by stress or anger, secondary to his pain. Dr. Hauser reviewed Claimant's past psychiatric history, including prescribed medications, and decided not to retry Remeron because it increases appetite and Claimant did not need weight increase. Dr. Hauser prescribed Cymbalta and gave him Seroquel as needed for insomnia. (EX-9, pp. 11-13).

Dr. Hauser related the panic disorder to Claimant's pain. The panic did not start until after the surgery, but he was having claustrophobic feelings prior to the surgery. The loss of control from the pain was causing Claimant's panic and subsequent depressive feelings. (EX-9, pp. 13-14).

He could not affirm whether Claimant had reached maximum medical improvement because he just examined Claimant for the first time in over one year. When Claimant treated regularly, Dr. Hauser controlled the panic attacks with some residual anxiety. From a psychiatric perspective, Dr. Hauser must rely on the truthfulness of Claimant's complaints and symptoms. Dr. Hauser did not have any objective way to verify Claimant was having panic attacks or anxiety attacks. (EX-9, pp. 14-15).

From a psychiatric perspective, Claimant's psychiatric condition does not preclude him from doing any type of work. Claimant's pain disorder is a physical condition and Dr. Hauser

is treating him purely for psychiatric conditions controllable through medication. If Claimant's physical condition gets better, then so will his psychiatric condition. (EX-9, p. 16).

Dr. Hauser recommended monthly follow-up visits. Once there was some progress he would reduce the visits to every two to three months, as maintenance. After a year or two of stabilization, he would determine whether Claimant should remain on medication. So long as a patient is on medication, Dr. Hauser needs to see them, but he might reduce the follow-up visits to every six months. (EX-9, p. 18).

Although litigation itself provides some stress and anxiety, Dr. Hauser could not agree that if those issues were resolved, the anxiety would be helped. Any kind of routine or structure is better psychologically then just sitting around a house. Although it would be good psychologically, it must be balanced against the risk of re-injury. (EX-9, p. 19).

Dr. Hauser's assessment of Claimant did not change from the first time he saw him until the last visit on September 10, 2004. Dr. Hauser has not corresponded with any of Claimant's orthopedic or pain doctors. When he first saw Claimant, Dr. Hauser's primary focus was what he described as anxiety from panic attacks. He noticed a small component of depression during Claimant's second or third visit. He started Claimant on Paxil, an anti-panic medication and antidepressant. Thus, he covered all the bases. He noticed dysphoria, which is why he continued to increase the Paxil. Remeron also helps both. (EX-9, pp. 20-22).

There was nothing in Dr. Hauser's notes reflecting exaggeration. He usually makes notations in the patient's records if he has any feeling of exaggeration. Claimant presented in a consistent manner. At no point did he feel the need to speak with Claimant's physicians or family. (EX-9, pp. 24-25).

Dr. Hauser was not aware Claimant was diagnosed with arachnoiditis, but knew of the term. Dr. Hauser tells all his patients with chronic pain that they will never really have total cure or live a completely pain-free life. If it does happen, it is icing on the cake, but they will have to live with the pain for the rest of their life. It does not make one's life horrible, it just places limitations on it. Treatment helps gear them to live with the pain. If Claimant can feel like he has some control over his pain, then Dr. Hauser thinks

the anxiety and panic will be better, increasing functionality. However, Dr. Hauser did not think Claimant would ever return to longshore work again. Claimant will need continued medication, for a couple of years, to help control the remaining anxiety once the panic attacks are under control. Claimant was fairly straightforward during questioning; therefore testing for assessment would have been a waste of time and money. (EX-9, pp. 26-30).

Claimant advised Dr. Hauser he did not treat from January 30, 2003 until September 10, 2004, because his insurance would not cover his visits. Dr. Hauser's staff contacted Carrier for authorization for treatment, but authorization was refused. (EX-9, pp. 30-31; CX-7, p. 1).

The Vocational Evidence

Larry Stokes, Ph.D.

The parties stipulated to Dr. Stokes's expertise in vocational rehabilitation. He met with Claimant on September 17, 2004, and rendered a report on October 4, 2004. He interviewed Claimant, did vocational testing and reviewed depositions and medical records. He also conducted a vocational analysis, determined alternative work, and did labor market research. (Tr. 83; EX-6, pp. 3-10).

Dr. Stokes found Claimant "needed assistance in the activities of daily living. He had a fifth grade education and he stated that he was only able to sign his name and address." Claimant has not worked since his November 1999 injury. His work history revealed work delivering paper, passing out fliers, detailing automobiles, and cleaning machine shops. (Tr. 84-85; EX-6, pp. 2-3).

Differences of opinion were reflected in Claimant's medical records; therefore Dr. Stokes wrote his report utilizing all opinions. It was Dr. Stokes's understanding that he was there to assess the injury regarding the left knee. He later found out about the right knee, back and psychiatric conditions. (Tr. 85).

Considering the different scenarios, Dr. Stokes identified certain jobs in the Houston area. He opined it is "within reasonable rehabilitation probability . . . that he could not return to work as a longshoreman, given the totality of the

medical information." Dr. Stokes also concluded that Claimant could not return to his past jobs. (Tr. 86).

"Sedentary to light work was bench assembler, courier messenger, hand packager, bagger." Dr. Stokes concluded that "given certain outcome scenarios, and assuming anticipated physical capacities . . . these would be the type of occupations [he] believed [Claimant] could perform, [but] not a full range of all those jobs." Dr. Stokes did not believe Claimant could operate a cash register, but there are retail jobs that do not operate cash registers at the light level. Claimant could hand out fliers for the retail store. (Tr. 87; EX-6, p. 13).

Dr. Stokes also performed labor market research to determine if there were employers hiring for jobs within Claimant's physical demand level. Dr. Stokes found some jobs available and listed their physical strength demands, job description, and weekly wages. Dr. Stokes wrote to the doctors to seek opinions on whether Claimant could perform those jobs. He has not received any responses on the original market research from any of the doctors about whether Claimant could perform any of the jobs. Dr. Stokes concluded, on October 4, 2004, Claimant's "vocational prognosis is poor, but can be upgraded following completion of his medical treatment." (Tr. 87-88; EX-6, pp. 14-15).

He received additional medical records, updated depositions and an OWCP-5 work restriction form from Dr. Bryan and wrote an addendum report dated October 8, 2004. Dr. Stokes did not have a copy of Dr. Gertzbein's OWCP-5 form and it was not considered. There were some discrepancies on the OWCP-5 by Dr. Bryan as to what Claimant could do.

> If you read the OWCP-5, it says that he can work eight hours a day. It also says that he can't work eight hours a day. It says that he can perform only sedentary work. But it says he can lift 20 to 50 pounds. So I just put that in the report in consideration for the judge to look at.

Dr. Stokes did not seek clarification from Dr. Bryan regarding these discrepancies. He wrote to the doctors regarding alternative jobs, but received differing opinions. Dr. Stokes did not believe it was his job to eliminate anything until there was clarification about what weight might be given to certain doctors. Dr. Stokes testified according to Dr. Sickler,

Claimant cannot work and according to Dr. Gertzbein, he could not do longshore work, but could possibly work in a light category defined as lifting no greater than 20 pounds. Finally, according to Dr. Bryan he could perform sedentary work with rehabilitation. Dr. Stokes's initial report remained unchanged. Certain records indicated Claimant was 100% disabled at times and others indicated he was not. According to Dr. Stokes, Dr. Gertzbein, Claimant's back doctor, indicated Claimant could do light work, while his knee doctor, Dr. Bryan, indicated sedentary work. However, after reviewing the OWCP-5, Dr. Stokes observed there is a "definite incongruence between what [Dr. Bryan] says he can do and what he fills out on the OWCP-5." (Tr. 88-91; EX-6, pp. 16-17).

It was Dr. Stokes's understanding that Dr. Bryan strictly treated the knees and Dr. Gertzbein only treated Claimant's back. Dr. Sickler considered Claimant's knees and back and determined he could not work at all. Although Claimant reported his panic attacks and treatment for depression, Dr. Stokes did not have Claimant's psychiatric records. (Tr. 91-93).

One of the jobs Dr. Stokes considered suitable for Claimant was as a "bell ringer." This job is seasonal from November 1st until December 23rd. Claimant informed Dr. Stokes that he wanted to find work that he could do, "something that could help with the anxiety and depression associated with the injuries and the resulting disability." Dr. Stokes admitted this was not a perfect job, but he tried to find something he thought Claimant would consider and could perform. He further acknowledged Claimant would not be able to perform these jobs at all times. (Tr. 93-94; EX-6, pp. 18-19).

Dr. Stokes discussed the other identified sedentary jobs. The ticket taker job was sedentary to light because it required standing. Dr. Stokes believed the job could be alternated in frequency, making it workable for Claimant. He also testified that the laser tag attendant job was sedentary to light, requiring some walking around. The OWCP-5 stated Claimant could walk two hours per day. Jobs are not considered sedentary if they require more than two hours of walking per day. (Tr. 94).

Dr. Stokes testified there was incongruence in how the OWCP-5 form was completed, but this was not unusual. According to the OWCP-5 work restrictions, Claimant could sit eight hours per day, walk two hours per day, lift zero, but the checked lifting restrictions were 20 to 50 pounds. The form also provided Claimant could not bend, lift, squat, or climb, but

could kneel from zero to one hour per day and could stand for one hour per day. Most patients in Dr. Stokes's experience will differentiate between standing and walking, indicating standing is more difficult than walking and will use walking to alleviate their problems from standing. (Tr. 95-96).

Dr. Stokes disagreed with Dr. Bryan's statement on March 7, 2001, that Claimant was 100 percent disabled from usual work, but could do sedentary work. Dr. Stokes opined "that perhaps at some point on 3/7/01, there was a point at which he could do sedentary work which also is in here because it actually defines the light lifting category which is up to 20 pounds by the Department of Labor standards." Dr. Stokes testified at times Claimant could have worked. He did not do a retroactive survey to determine if the identified jobs were available at that time. Based on the OWCP-5 form allowing Claimant to walk for two hours, sit for eight, Dr. Stokes concluded Claimant should be able to do sedentary to light duty work. He based this opinion on the OWCP-5 limitations, excluding Dr. Sickler's opinion that Claimant could not work at all. (Tr. 96-97).

On cross-examination, Dr. Stokes defined sedentary work using the Department of Labor definition, as "mostly sitting, up to eight hours per day, some standing and walking, less than two hours per day, and no lifting greater than ten pounds, either frequently or occasionally." Dr. Stokes testified that Dr. Bryan's restrictions do not meet the definitions as outlined by the Department of Labor. Sedentary work can consist of eight hours of sitting, "different jobs require different things." To make Dr. Bryan's restrictions work, Dr. Stokes presumed that after October 2004, Claimant could do sedentary work for eight hours a day. Dr. Bryan first reported on the OWCP-5 that Claimant could not work eight hours a day, then reported under item 12(b), that as of October 2004, he could perform only sedentary work. Dr. Stokes's working presumption from reviewing the OWCP-5 is that Claimant could sit up to eight hours per day. He noted "the working assumption here is that since this is a work restriction for, [Dr. Stokes went] on the hypothesis that this means ability to work and sit eight hours per day." Because of the different possible interpretations of Dr. Bryan's conflicting responses to item 12(a), Dr. Stokes looked for part-time work as well. (Tr. 97-101).

A light duty job is defined as "[s]tanding or walking up to six hours per day, and lifting up to 20 pounds occasionally, with frequent lifting up to 10 pounds." Under Dr. Bryan's restrictions, Claimant would not be able to perform light duty

work. The banquet hall ticket taker job, which was no longer available, required Claimant to direct patrons to parties and various banquet rooms. The job required minimal reading. Claimant would be required to know which rooms were for which parties. Dr. Stokes felt that based on Claimant's work experience as a foreman, he could probably work as a ticket taker. Dr. Stokes did not find another ticket taker job available anywhere in Houston. The bell ringer job was still hiring as of the formal hearing to begin in November. Dr. Stokes considered the bell ringer job available immediately. Dr. Stokes testified Dr. Bryan informed his office manager that Claimant could perform the bell ringer job. (Tr. 101-104).

Dr. Stokes's typical understanding of a laser tag attendant's duties, included taking care of laser tag parties and events. It would require Claimant to check people in and make sure they obey the rules, look after the kids playing laser tag and take tickets as they enter the play area. The laser tag attendant job was for part-time work and was sedentary to light, lifting under ten pounds, and some standing and walking. Dr. Stokes considered various factors in finding potential work for Claimant including his educational level. A laser tag attendant meets Claimant's physical and vocational requirements. According to Dr. Stokes, climbing is not defined as walking up steps, but is defined as climbing ladders, ropes and scaffolds. Dr. Stokes admitted some doctors do not differentiate between climbing stairs and climbing ladders. If the laser tag attendant job required Claimant to walk up various flights of stairs, Dr. Stokes does "not believe that [Claimant] could." (Tr. 105-107).

When Dr. Stokes looked at the laser tag attendant job, he also looked at it in relationship to Claimant's doctors' opinions, particularly Dr. Gertzbein who limited Claimant to light work. According to Dr. Gertzbein's limitations, Claimant could perform the laser tag job. If Dr. Bryan opined Claimant has difficulty climbing stairs and stairs were involved in the job, the job would be considered inappropriate for Claimant. (Tr. 107).

Taking into consideration the testimony of Claimant and his wife that he has to get off of his feet several times during the day and lay down because of his discomfort and pain, Dr. Stokes would eliminate him from working competitively in any job. All of Dr. Stokes's opinions were based on standard work weeks and maintaining employment. (Tr. 108).

Because Claimant reported panic attacks at night while sleeping and may have difficulties being in crowds or around people, Dr. Stokes agreed Claimant could not perform work as a ticket taker; however, since Dr. Stokes was not provided with Claimant's psychiatric records or the psychiatrist's deposition, he deferred any determination of Claimant's functional limitations to the psychiatrist or psychologist. (Tr. 110).

The Contentions of the Parties

Claimant contends his right knee condition is a related consequential injury from the original left-knee injury. He asserts the torn meniscus in his right knee is related to the additional stress placed on his right knee because of limping and guarding his back. It is his position that based upon his left knee condition alone he remains totally and permanently disabled.

In addition, Claimant maintains he has not reached maximum medical improvement from his spinal condition. He further contends there is no change of condition which would improve his ability to seek or gain suitable employment. Claimant asserts he is unable to read or write and therefore, even sedentary employment identified by Employer/Carrier's vocational expert is beyond his vocational capabilities.

On the other hand, Employer/Carrier contend Claimant has had a substantial change in his physical condition since the first Decision and Order. Employer/Carrier also contend suitable alternate employment has been identified regarding Claimant's work capacity involving his left knee. Therefore, Employer/Carrier assert Claimant's status should be changed from permanent total disability of the left knee to permanent partial disability of the left knee.

Employer/Carrier further maintain that suitable alternate employment as to Claimant's left knee is a totally different issue than whether Claimant can perform this employment based on his back, right knee, psychiatric condition, and left knee combined. The undersigned is requested to differentiate whether there has been a substantial change in Claimant's condition such that Employer/Carrier can establish evidence of suitable alternate employment as to his left knee only.

In addition, Employer/Carrier contend Claimant reached maximum medical improvement as to his back and can return to some form of work. Finally, Employer/Carrier contend Claimant's

right knee condition is not related to his work-related left knee injury.

IV. DISCUSSION

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

An administrative law judge has the discretion to determine the credibility of witnesses. Furthermore, an administrative law judge may accept a claimant's testimony as credible, despite inconsistencies, if the record provides substantial evidence of the claimant's injury. Kubin v. Pro-Football, Inc., 29 BRBS 117, 120 (1995); see also Palquemines Equipment & Machine Co. v. Newman, 460 F.2d 1241, 1243 (5th Cir. 1972).

A. Section 22 Modification – Change in Physical/Medical Condition

Section 22 of the Act provides the only means for changing otherwise final decisions on a claim. Modification pursuant to this section is permitted based upon a mistake of fact in the initial decision or a change in claimant's physical or economic condition. See Metropolitan Stevedore Co. v. Rambo [Rambo I], 515 U.S. 291, 115 S. Ct. 2144, 30 BRBS 1 (1995). The rationale

for allowing modification of a previous compensation award is to render justice under the Act.

The party requesting modification has the burden of proof to show a mistake of fact of change in condition. See Vasquez v. Continental Maritime of San Francisco, Inc., 23 BRBS 428 (1990); Winston v. Ingalls Shipbuilding, Inc., 16 BRBS 168 (1984).

Where a party seeks modification based on a change in condition, as here, an initial determination must be made as to whether the petitioning party has met the threshold requirement by offering evidence demonstrating a mistake of fact or that there has been a change in Claimant's condition. Duran v. Interport Maintenance Corp., 27 BRBS 8 (1993); Jensen v. Meeks Marine, Inc., 34 BRBS 147 (2000). This inquiry does not involve a weighing of the relevant evidence of record, but rather is limited to a consideration of whether the newly submitted evidence is sufficient to bring the contention within the scope of Section 22. If so, the administrative law judge must determine whether modification is warranted by considering all of the relevant evidence of record to discern whether there was, in fact, a mistake of fact or a change in physical or economic condition. Id. at 149.

An administrative law judge, as trier of fact, has broad discretion to modify a compensation order. O'Keefe v. Aerojet-General Shipyards, Inc., 404 U.S. 254, 92 S. Ct. 405 (1971), reh'g denied, 404 U.S. 1053 (1972). Modification based upon a change in conditions or circumstances has been interpreted broadly. Rambo I, 515 U.S. at 296. Once the moving party submits evidence of a change in condition, the standards for determining the extent of disability are the same as in the initial proceeding. See Rambo I, 515 U.S. at 296; Delay v. Jones Washington Stevedoring Co, 31 BRBS 197 (1998); Vasquez, 23 BRBS at 431.

Section 22 is not intended as a basis for re-trying or re-litigating issues that could have been raised in the initial proceeding or for correcting litigation strategy/tactics, errors or misjudgments of counsel. General Dynamics Corp. v. Director, OWCP [Woodberry], supra; McCord v. Cephas, 532 F.2d 1377, 3 BRBS 371 (D.C. Cir. 1976); Delay, 23 BRBS at 204.

Employer/Carrier is not seeking modification under Section 22 of the Act based on a mistake of fact or change in wage-earning capacity. Rather Employer/Carrier maintain Claimant's

left knee has improved to the extent that its status should now be changed from permanent total disability to permanent partial disability.

In the instant case, Employer/Carrier seek Section 22 modification and therefore has the burden of establishing there has been a change in Claimant's physical condition. A determination must be made as to whether Claimant's status has changed from permanent total disability of the left knee to permanent partial disability. A determination must also be made as to the permanency of Claimant's back and right knee conditions.

The undersigned originally found in the July 2002 Decision and Order, that Claimant reached MMI as to his left knee on November 12, 2001, and due to his residual impairments, his disability reached permanency on that date.

Employer/Carrier have now identified theoretical suitable alternative employment for Claimant based on his alleged improved left knee despite the fact that Claimant may not be able to perform such work due to his back, right knee and psychiatric conditions.

Although Claimant had arthroscopic surgery to his left knee in 2004, to improve his ability to perform work, Dr. Bryan opined Claimant's knee problems were worse than the MRIs indicated. During the recovery or convalescence period after surgery, Dr. Bryan indicated Claimant was not at maximum medical improvement. Dr. Bryan "cleaned up" the area to relieve some of the pain Claimant was experiencing.

Contrary to Employer/Carrier's argument, Claimant reached a state of permanency as to his left knee in November 2001. Although he was considered temporarily disabled by Dr. Bryan while recovering after his arthroscopic procedure, the permanency of his left knee is not altered even though its condition may improve or deteriorate. See Davenport v. Apex Decorating Company, Inc., 18 BRBS 194, 196-197 (1986) (MMI assigned on two separate dates).

Dr. Bryan completed an OWCP-5 form which indicated Claimant could perform sedentary work for eight hours per day if only his knees are considered. Dr. Bryan opined Claimant reached MMI after his arthroscopic surgery on August 24, 2004. Dr. Fulford also opined Claimant should be able to perform sedentary work considering his knee and back conditions. Thus,

Employer/Carrier argue modification is warranted since Claimant's left knee has improved to the extent that he can perform sedentary work for eight hours per day. This newly submitted evidence is sufficient to bring the claim within the scope of Section 22 of the Act. See Jensen, supra.

B. The Right Knee Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

> In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary-that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which **could have caused** the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

1. Claimant's Prima Facie Case

The parties do not dispute that Claimant's left knee and back injuries were caused by his work-related accident however, it is disputed whether Claimant's subsequent right knee problems were caused by, or a result of, his November 26, 1999 injury, and its residuals, or due to unrelated degenerative disease.

Claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm

necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT)(5th Cir. 1982).

In the present matter, Claimant complained of pain to his right knee after his back surgery for his work-related injury of November 26, 1999. Claimant contends his right knee problems were a result of his "limping off of his left leg." He did not have problems with his right knee prior to his back surgery and subsequent limping. His right knee began hurting after he started putting most of his weight on his right leg because his left knee hurt too much. To relieve the pain in his left knee, he would walk on his "right foot." Arguably, based on Claimant's credible testimony, his right knee injury is related to his work accident/injury and its sequela.

By January 2003, Claimant was referred by Dr. Bryan to Dr. Sickler for chronic pain management for what Dr. Bryan described as an aggravation of his spinal condition from walking with a significant limp. Claimant complained of pain in both knees and it was Dr. Byran's opinion that he was favoring his left side, placing an additional load on the right knee. According to Dr. Bryan, the MRI showed two important changes – chrondromalacia (early arthritis) and worn down surface cartilage. Dr. Bryan opined the increased arthritis and tears in Claimant's right knee were a natural progression of his November 26, 1999 injury, because of the additional stress placed on both knees.

Thus, Claimant has established a **prima facie** case that he suffered a right knee "injury" under the Act, having established that he originally suffered a harm or pain on November 26, 1999, and that his post-surgical activities could have caused the harm or pain to his right knee sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

2. Employer's Rebuttal Evidence

Once Claimant's **prima facie** case is established, a presumption is invoked under Section 20(a) that supplies the causal nexus between the physical harm or pain and the work injury and its residuals which could have caused them.

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Claimant's condition was neither caused by his work-related accident/injury

and its residuals nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194 F.3d 684, 33 BRBS 187 (CRT)(5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT)(5th Cir. 1998); Louisiana Ins. Guar. Ass'n v. Bunol, 211 F.3d 294, 34 BRBS 29(CRT)(5th Cir. 1999); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT)(5th Cir. 1994);. "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. Avondale Industries v. Pulliam, 137 F.3d 326, 328 (5th Cir. 1998); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

In the present matter, Employer/Carrier presented the medical testimony of Dr. Fulford, who testified Claimant's right knee problem is not related to Claimant's left knee injury. Dr. Fulford explained that nothing in the medical literature suggests that extra stress on a knee, limping or a short leg, causes degenerative changes in the other knee. Dr. Fulford further opined that Claimant's back difficulties did not cause Claimant's right knee problems.

Thus, I find that Employer/Carrier rebutted Claimant's **prima facie** claim that the November 26, 1999 accident, and its residuals, caused Claimant to develop a compensable right knee injury.

3. Weighing all the evidence

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119(CRT)(4th Cir. 1997); Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Prefatorily, it is noted the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician under certain circumstances. Black & Decker Disability Plan v. Nord, 123 S.Ct. 1965, 1970 n. 3 (2003) (in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physicians rule in which the opinions of treating physicians are accorded special deference) (citing Pietrunti v. Director, OWCP, 119 F.3d 1035 (2d Cir. 1997) (an administrative law judge is bound by the expert opinion of a treating physician as to the existence of a disability "unless contradicted by substantial evidence to the contrary")); Rivera v. Harris, 623 F.2d 378 (5th Cir. 2000) (in a Social Security matter, the opinions of a treating physician were entitled to greater weight than the opinions of non-treating physicians).

Claimant testified his right knee problems did not start until he began walking subsequent to his back surgery. He experienced increasing pain and discomfort in his left knee which caused him to walk with a limp, placing most of his weight onto the right side of his body. His right foot started swelling, causing Claimant severe pain.

Dr. Bryan is Claimant's treating orthopedic surgeon regarding his knees. Dr. Bryan treated Claimant's left knee after his 1999 injury and noted that Claimant's right knee had degenerative disease, but was asymptomatic. Claimant reported severe right knee pain to Dr. Bryan on September 3, 2003, and Dr. Bryan ordered MRIs of both knees. The MRIs showed grade three medial meniscal tears and he recommended bilateral knee arthoroscopy because the meniscus tears were pain generators and Claimant was describing sharp pains. Dr. Bryan opined that if Claimant did not have the recommended surgeries, he would be less likely to return to any form of employment.

It was Dr. Bryan's opinion that Claimant's knees were steadily worsening and there were no intervening injuries or medical treatment that would have caused the problems Claimant was experiencing. Claimant was favoring his left side, placing an additional load on his right side. There were major differences between Claimant's 2002 MRI and 2003 MRI. The surface cartilage was worn down and he developed tears in the menisci of the right knee. According to Dr. Bryan, Claimant's new difficulties related to his 1999 injury because of the additional stress he placed on his right side, not because of mere deterioration with age.

The 2004 arthroscopy revealed medial and lateral meniscus tears to the right knee. The surgery brought significant pain relief to Claimant's right knee and helped Claimant walk with minimal gait support. According to Dr. Bryan, Claimant's right knee problems and surgery were related to his original left knee injury aggravated by limping. His opinion was based on his observations of the changes that appeared to the right knee and the fact that it was overloaded. Dr. Bryan found even more damage to the right knee during surgery then he had anticipated. The joint surface cartilage was worn down almost to the bone. Even though Dr. Bryan did not treat Claimant's spine, he also opined Claimant's lumbar problems "probably" added to his right knee problem.

Dr. Fulford examined Claimant at Employer/Carrier's request. He noted during his examination that Claimant was constantly leaning toward his right side. Claimant also appeared to have a painful and antalgic gait to both the left and right side. In contrast from Dr. Bryan, however, Dr. Fulford would not relate Claimant's right knee condition to his compensable left knee injury. Although Claimant complained of severe right knee pain and had abnormal gait, Dr. Fulford opined the right knee pain did not relate to the 1999 injury because "the literature" did not substantiate such a conclusion.

Dr. Fulford explained his inconsistent opinion with those of Claimant's treating physicians because he performed objective tests to determine whether Claimant was magnifying his symptoms. Dr. Fulford concluded Claimant's ambulating problem was not as bad as Claimant would indicate and that there were other signs of exaggeration. Dr. Fulford acknowledged, however, he was not qualified to talk about "the switching of nerves" and their functions which may cause the brain to react to normal touching with severe pain. Although Claimant exhibited more pain then would be expected, it is a reaction to arachnoiditis which is incurable. Dr. Fulford opined because there was no history of any injury to the right knee other than excessive or extra force, the mensical tear was due to a degenerative meniscus. Dr. Bryan specifically testified that the type of injury present in Claimant's right knee could not be caused by mere excessive or extra force.

Although Dr. Fulford examined Claimant on three separate occasions, the examinations were single evaluations and no treatment was provided to Claimant by Dr. Fulford. Dr. Bryan was Claimant's treating physician who treated Claimant

consistently since October 2000. Accordingly, I place more probative weight and value on the records, reports and opinions of Dr. Bryan, than those of Dr. Fulford, because of his familiarity with Claimant's symptoms, the frequency of such symptoms, and treatment.

Even though Dr. Fulford reported signs of symptom magnification because Claimant showed guarding of his muscles, the record also shows evidence of arachnoiditis which causes Claimant to feel light touch as severe pain. This was not evidenced during Dr. Fulford's first two examinations of Claimant, however during Dr. Fulford's September 2004 examination, it was evident.

Dr. Fulford's only dispute as to whether Claimant's right knee pain was caused by placing additional weight to the left side when limping, was that the "literature did not support" such a finding. He would not affirm that he never experienced patients with a bad gait or limp who also developed back pain. He only reiterated that the literature did not support it. He even admitted Claimant's treating physicians saw Claimant more often then he did and a greater opportunity to observe him.

In conclusion, I find Claimant suffered a compensable work-related right knee injury as a result of his November 26, 1999 work injuries, and the residual difficulties resulting therefrom include limping which aggravated his right knee. The records and opinions of Dr. Bryan indicate the work accident aggravated Claimant's underlying chondromalacia and caused a subsequent medial and lateral meniscus tear to Claimant's right knee which necessitated arthroscopic surgery. Accordingly, I find and conclude Claimant's aggravated right knee problem is compensable.

C. Suitable Alternative Employment

Having found that the threshold indicia for modification has been met and that Claimant's right knee condition is a residual of his work-related accident/injury, vocational issues must be evaluated since Claimant was found totally disabled in the original Decision and Order.

Under the Act, an employer may attempt to modify a total disability award by establishing the availability of suitable alternative employment. The employer is allowed this modification attempt because the factors initially considered by the judge may be revisited on modification. Fleetwood v.

Newport News Shipbuilding & Dry Dock Co., 776 F.2d 1225 (4th Cir. 1985). Addressing the issue of job availability, the Fifth Circuit has developed a two-part test by which an employer can meet its burden:

> (1) Considering claimant's age, background, etc., what can the claimant physically and mentally do following his injury, that is, what types of jobs is he capable of performing or capable of being trained to do?
>
> (2) Within the category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which the claimant is able to compete and which he reasonably and likely could secure?

Id. at 1042. Turner does not require that employers find specific jobs for a claimant; instead, the employer may simply demonstrate "the availability of general job openings in certain fields in the surrounding community." P & M Crane Co. v. Hayes, 930 F.2d 424, 431 (1991); Avondale Shipyards, Inc. v. Guidry, 967 F.2d 1039 (5th Cir. 1992).

However, the employer must establish **the precise nature and terms** of job opportunities it contends constitute suitable alternative employment in order for the administrative law judge to rationally determine if the claimant is physically and mentally capable of performing the work and that it is realistically available. Piunti v. ITO Corporation of Baltimore, 23 BRBS 367, 370 (1990); Thompson v. Lockheed Shipbuilding & Construction Company, 21 BRBS 94, 97 (1988).

The administrative law judge must compare the jobs' requirements identified by the vocational expert with the claimant's physical and mental restrictions based on the medical opinions of record. Villasenor v. Marine Maintenance Industries, Inc., 17 BRBS 99 (1985); See generally Bryant v. Carolina Shipping Co., Inc., 25 BRBS 294 (1992); Fox v. West State, Inc., 31 BRBS 118 (1997). Should the requirements of the jobs be absent, the administrative law judge will be unable to determine if claimant is physically capable of performing the identified jobs. See generally P & M Crane Co., 930 F.2d at 431; Villasenor, supra. Furthermore, a showing of only one job opportunity may suffice under appropriate circumstances, for example, where the job calls for **special skills** which the claimant possesses and there are few qualified workers in the

local community. P & M Crane Co., 930 F.2d at 430. Conversely, a showing of one **unskilled** job may not satisfy Employer's burden.

Once the employer demonstrates the existence of suitable alternative employment, as defined by the Turner criteria, the claimant can nonetheless establish total disability by demonstrating that he tried with reasonable diligence to secure such employment and was unsuccessful. Turner, 661 F.2d at 1042-1043; P & M Crane Co., 930 F.2d at 430. Thus, a claimant may be found totally disabled under the Act "when physically capable of performing certain work but otherwise unable to secure that particular kind of work." Turner, 661 F.2d at 1038, quoting Diamond M. Drilling Co. v. Marshall, 577 F.2d 1003 (5th Cir. 1978).

Employer/Carrier advance a unique theory that if Claimant's left knee injury is considered alone, without regard to his other multiple problems, Claimant can perform sedentary work as identified by their vocational expert and, thus, his total disability should be changed to partial disability.

Employer/Carrier rely upon the opinions of Dr. Bryan and Dr. Fulford that, based on Claimant's left knee injury alone, he can perform sedentary work eight hours per day. Of the jobs identified by Dr. Stokes, Dr. Bryan approved only the seasonal bell ringer job, if Claimant had only knee problems. However, Dr. Bryan further opined that Claimant could not work an eight hour day as a bell ringer even if he alternated sitting and standing. Dr. Bryan opined that if Claimant's knee problems were considered in conjunction with his back condition, he could not perform the bell ringer job.

Dr. Gertzbein reasonably and credibly concluded Claimant has not reached MMI for his back condition and could not work in any capacity as of August 26, 2004, because of his pain from arachnoiditis.

Dr. Sickler did not assign Claimant an MMI date and recommended continuous conservative care from a pain management perspective for his back condition. He opined Claimant could not return to work in any capacity, not even sedentary work.

Dr. Hauser opined that Claimant was not at MMI for his psychological condition but was not precluded from doing any type of work because of his condition.

Only Dr. Fulford concluded that Claimant's knee and back conditions would not prevent him from performing sedentary work for eight hours a day. He also concluded that Claimant, whom he had not treated, was at MMI for his knee and back conditions. Nor did he think arachnoiditis, which he agreed may cause chronic pain, would preclude Claimant from doing sedentary work. As previously noted, I place little or no probative value on Dr. Fulford's opinions which are isolated from the majority of medical opinions in this case.

Dr. Stokes opined that it was within reasonable "rehabilitation probability" that Claimant could not return to his former employment as a longshoreman. He acknowledged that Claimant's vocational prognosis is poor, "but can be upgraded following completion of his medical treatment."

Dr. Stokes's opinions are based on his interpretation of Dr. Bryan's opinion that Claimant could perform sedentary work and Dr. Gertzbein's 2002 opinion that Claimant would "probably [be] restricted to no lifting more than 20 pounds." He erroneously concluded that Dr. Gertzbein indicated Claimant could do light work. Dr. Stokes did not receive nor consider Dr. Gertzbein's 2004 OWCP-5 form which indicated Claimant could perform no work "at this time" because he may need more surgery with lifting limited to 0-10 pounds. He apparently also relied on Dr. Fulford who expressed an opinion that Claimant could perform work at the sedentary level.

Accordingly, it is apparent that the basis of Dr. Stokes's conclusions is the opinions of Dr. Bryan and Dr. Fulford who opined Claimant could perform sedentary work when only his left knee limitations are considered. However, after reviewing the identified jobs, Dr. Bryan limited Claimant to the bell ringer job.

Although Claimant's left knee alone may allow him to engage in seasonal sedentary employment as a bell ringer, I find and conclude that the totality of Claimant's conditions, including his disabling pain, his back problems and new right knee condition, and his limitations on sitting and standing which require him to lie down daily for pain relief, preclude his engaging in any of the identified suitable alternative employment. I find Employer/Carrier's theory that Claimant can perform sedentary work if only his left knee is considered, to be a distinction without a difference. Accordingly, I find and conclude that modification based on Claimant's left knee condition alone is not warranted and is therefore **DENIED.**

D. Entitlement to Medical Care and Benefits

Section 7(a) of the Act provides that:

> The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

33 U.S.C. § 907(a).

The Employer is liable for all medical expenses which are the natural and unavoidable result of the work injury. For medical expenses to be assessed against the Employer, the expense must be both reasonable and necessary. Pernell v. Capitol Hill Masonry, 11 BRBS 532, 539 (1979). Medical care must also be appropriate for the injury. 20 C.F.R. § 702.402.

A claimant has established a **prima facie** case for compensable medical treatment where a qualified physician indicates treatment was necessary for a work-related condition. Turner v. Chesapeake & Potomac Tel. Co., 16 BRBS 255, 257-258 (1984).

Section 7 does not require that an injury be economically disabling for claimant to be entitled to medical benefits, but only that the injury be work-related and the medical treatment be appropriate for the injury. Ballesteros v. Willamette Western Corp., 20 BRBS 184, 187.

Entitlement to medical benefits is never time-barred where a disability is related to a compensable injury. Weber v. Seattle Crescent Container Corp., 19 BRBS 146 (1980); Wendler v. American National Red Cross, 23 BRBS 408, 414 (1990).

An employer is not liable for past medical expenses unless the claimant first requested authorization prior to obtaining medical treatment, except in the cases of emergency, neglect or refusal. Schoen v. U.S. Chamber of Commerce, 30 BRBS 103 (1997); Maryland Shipbuilding & Drydock Co. v. Jenkins, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979), rev'g 6 BRBS 550 (1977). Once an employer has refused treatment or neglected to act on claimant's request for a physician, the claimant is no longer obligated to seek authorization from employer and need only establish that the treatment subsequently procured on his own initiative was necessary for treatment of the injury. Pirozzi v. Todd

Shipyards Corp., 21 BRBS 294 (1988); Rieche v. Tracor Marine, 16 BRBS 272, 275 (1984).

The employer's refusal need not be unreasonable for the employee to be released from the obligation of seeking his employer's authorization of medical treatment. See generally 33 U.S.C. § 907 (d)(1)(A). Refusal to authorize treatment or neglecting to provide treatment can only take place after there is an opportunity to provide care, such as after the claimant requests such care. Mattox v. Sun Shipbuilding & Dry Dock Co., 15 BRBS 162 (1982). Furthermore, the mere knowledge of a claimant's injury does not establish neglect or refusal if the claimant never requested care. Id.

In the present matter, Claimant requested Employer/Carrier's authorization to receive medical treatment on numerous occasions. Carrier discontinued treatment with Dr. Sickler, Dr. Hauser and also refused to pay for his right knee surgery and subsequent care. Claimant was able to receive assistance from his personal health insurance carrier, which required co-payments for such treatment.

Although Claimant requested authorization before seeking medical treatment, to be reimbursed for such treatment he must also establish the medical care was reasonable and necessary. Dr. Bryan, Dr. Sickler, and Dr. Gertzbein all agreed Claimant's medical treatment was necessary. In addition, although Employer/Carrier refused to pay for his psychiatric treatment, they stipulated that Claimant developed a psychiatric condition related to his work injury and have actually paid for his psychiatric medication. While Dr. Fulford denied the right knee problem was related to the 1999 injury, he agreed that the right knee surgery was reasonable and necessary. Thus, I find Claimant's right knee surgery and subsequent care was reasonable and necessary for his recovery.

Dr. Gertzbein and Dr. Sickler have treated Claimant's back injury conservatively and Dr. Fulford deferred to Dr. Gertzbein for any comment related to Claimant's back treatment. Therefore, I also find the recommended health club membership and pain management treatment to be reasonable and necessary for his recovery.

Since Claimant may still benefit from additional back modalities, such as a dorsal column stimulator, and PNT, I find consistent with Dr. Gertzbein's opinion, that he has not reached MMI for his back condition. However, even though Claimant's

knee arthroscopies were "cleanup" procedures of a routine nature to reduce buildup and pain, I find Claimant to be at MMI for both knees since, according to Dr. Bryan, additional surgery and treatment will not correct Claimant's knee problems, but only provide temporary relief.

Claimant's panic attacks only developed after his back surgery and were diagnosed as post-surgical trauma syndrome by Dr. Gertzbein. Claimant has been treating with Dr. Hauser whenever his private insurance carrier would permit because Employer/Carrier have refused to authorize such treatment even though they have paid for the psychiatric medication. When a treating physician refers a claimant to a psychiatrist, he is providing the care of a specialist whose services are necessary for the treatment of the compensable injury. Armfield v. Shell Offshore, 25 BRBS 303, 309 (1992).

Employer/Carrier have been found liable for Claimant's November 26, 1999 work injury and its sequelae. Accordingly, Employer/Carrier are responsible for all reasonable and necessary medical expenses related to Claimant's aggravated chondromalacia in the left and right knee and degenerative disease condition, including his right knee surgery, psychiatric treatment, and subsequent back care.

V. SECTION 14(e) PENALTY

Section 14(e) of the Act provides that if an employer fails to pay compensation voluntarily within 14 days after it becomes due, or within 14 days after unilaterally suspending compensation as set forth in Section 14(b), the Employer shall be liable for an additional 10% penalty of the unpaid installments. Penalties attach unless the Employer files a timely notice of controversion as provided in Section 14(d).

Penalties were listed as a generic issue by the parties. Penalties were awarded in the original Decision and Order after which Claimant has received continuous payment of permanent total disability. I note Claimant has not argued in his brief for additional penalties nor do I find any penalties warranted.

VI. INTEREST

Although not specifically authorized in the Act, it has been an accepted practice that interest is assessed on all past due compensation payments. Avallone v. Todd Shipyards Corp., 10 BRBS 724 (1974). The Benefits Review Board and the Federal

Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed percentage rate no longer appropriate to further the purpose of making Claimant whole, and held that ". . . the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (1982). Grant v. Portland Stevedoring Company, et al., 16 BRBS 267 (1984). Effective February 27, 2001, this interest rate is based on a weekly average one-year constant maturity Treasury yield for the calendar week preceding the date of service of this Decision and Order by the District Director. This order incorporates by reference this statute and provides for its specific administrative application by the District Director.

VII. ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision by the District Director to submit an application for attorney's fees.[3] A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

[3] Counsel for Claimant should be aware that an attorney's fee award approved by an administrative law judge compensates only the hours of work expended between the close of the informal conference proceedings and the issuance of the administrative law judge's Decision and Order. Revoir v. General Dynamics Corp., 12 BRBS 524 (1980). The Board has determined that the letter of referral of the case from the District Director to the Office of the Administrative Law Judges provides the clearest indication of the date when informal proceedings terminate. Miller v. Prolerized New England Co., 14 BRBS 811, 813 (1981), aff'd, 691 F.2d 45 (1st Cir. 1982). Thus, Counsel for Claimant is entitled to a fee award for services rendered after **May 7, 2004**, the date this matter was referred from the District Director.

VIII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, I enter the following Order:

1. Employer/Carrier's request for modification to change Claimant's left knee status from permanent total disability to permanent partial disability is **DENIED.**

2. Claimant's right knee condition and psychiatric condition are compensable injuries related to his November 26, 1999 injury, and Employer/Carrier are responsible for all reasonable and necessary medical care and treatment related to the Claimant's right knee and psychiatric condition.

3. Employer/Carrier shall pay all reasonable, appropriate and necessary medical expenses arising from Claimant's November 26, 1999 work injury, including medical care and treatment for his right knee surgery and subsequent care, psychiatric treatment, pain management care and health club membership, and any past due medical bills or reimbursement to Claimant for payments for treatment from Texas Orthopedic Hospital for Claimant's original left knee injury, pursuant to the provisions of Section 7 of the Act.

4. Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

5. Claimant's attorney shall have thirty (30) days from the date of service of this decision by the District Director to file a fully supported fee application with the Office of Administrative Law Judges; a copy must be served on Claimant and opposing counsel who shall then have twenty (20) days to file any objections thereto.

ORDERED this 8th day of April, 2005, at Metairie, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge